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Orientation

How To Use This Manual

This manual is divided into sections. Pages are numbered consecutively within each section in the format: section # - page #. Page 1 of Section 1 is "1-1", page 1 of Section 2 is "2-1", etc.

Each menu section begins with an overview of the options contained in it, followed by the actual option documentation. Most option documentation will contain the following components.

Introduction	The introduction gives a detailed description of the option and what it is used for. It will contain any special instructions related to the option.
Process Chart	The process chart illustrates the flow of the option step-by-step, giving the various choices and subsequent progression at each step.
Example	The example displays what you might see on the screen when using the option. A sample of any hard copy reports, MailMan messages, etc. generated by the option are usually included here.

The Process Charts will not contain documentation of the system's responses to erroneous input. In certain instances, in order to preserve the integrity of previously entered data, the system will not allow the entry of an up-arrow. This also may not be documented.

All user responses in this manual are shown in boldface type. The symbol **<RET>** is used to show when you are to press the Return or Enter key as your response to the prompt. The symbol <^> is used when referring to the up-arrow (caret).

Many options/menus in the IB package appear in more than one place on the menu structure. Generally, the documentation for a specific menu/option will only be provided in one section of the manual. You can refer to the Index of this user manual for the location of any specific option/menu documentation.

The following icons are used to highlight key points in the option documentation.

Required security keys

Enhancements and functionality changes

SECTION 1- BILLING CLERK'S MENU

Claims Tracking Menu for Billing
Enter/Edit Billing Information
Automated Means Test Billing Menu
CHAMPUS Billing Menu
Patient Billing Reports Menu
Third Party Joint Inquiry
Third Party Billing Menu

Option Overview

ENTER/EDIT BILLING INFORMATION - Used to enter the information required to generate a third party bill and to edit existing billing information.

AUTOMATED MEANS TEST BILLING MENU

CANCEL/EDIT/ADD PATIENT CHARGES - Allows you to manually cancel, edit or add per diem and copayment patient charges or fee services for a specified patient and date range.

PATIENT BILLING CLOCK MAINTENANCE - Allows adding or editing of patient billing clocks.

ESTIMATE CATEGORY C CHARGES FOR AN ADMISSION - Used to estimate the Means Test/Category C charges for an episode of hospital or nursing home care for a proposed length of stay.

ADD/EDIT PTS. CONTINUOUSLY HOSPITALIZED SINCE 1986 - Allows you to add or edit entries in the CONTINUOUS PATIENT file (#351.1) for patients continuously hospitalized at the same level of care since 1986.

ON HOLD MENU

HELD CHARGES REPORT - Provides a list of all charges with a status of ON HOLD. Charges for Category C patients with insurance are placed ON HOLD until the patient's insurance company bill is resolved.

RELEASE CHARGES 'ON HOLD' - Used to release Means Test Category C charges, with a status of ON HOLD, to Accounts Receivable.

LIST CHARGES AWAITING NEW COPAY RATE - Used to generate a list of all Means Test outpatient copayment charges which have been placed on hold because the copay rate is over one year old.

SEND CONVERTED CHARGES TO A/R - Designed for use after the Integrated Billing conversion is completed. After the conversion, certain inpatient and outpatient charges will have a status of CONVERTED. This option allows you to choose which converted charges are passed to Accounts Receivable.

RELEASE CHARGES 'PENDING REVIEW' - Used to release charges which have been created as a result of an Income Verification Match (IVM) verified Means Test being received and filed at the medical facility.

RELEASE CHARGES AWAITING NEW COPAY RATE - Used to release charges which have been placed on hold because the outpatient copay rate is over one year old.

PATIENT BILLING CLOCK INQUIRY - Allows you to display data contained in the patient billing clock.

CATEGORY C BILLING ACTIVITY LIST - Used to list all Means Test/Category C charges within a specified date range.

SINGLE PATIENT CATEGORY C BILLING PROFILE - Provides a list of all Means Test/Category C charges within a specified date range for a selected patient.

DISPOSITION SPECIAL INPATIENT BILLING CASES - Used to enter the reason for not billing inpatient billing cases for veterans whose care is related to their exposure to Agent Orange, ionizing radiation, or environmental contaminants.

LIST SPECIAL INPATIENT BILLING CASES - Used to provide a listing of all special inpatient billing cases, both dispositioned and undispositioned.

CHAMPUS BILLING MENU

DELETE REJECT ENTRY - Allows you to delete individual entries from the CHAMPUS PHARMACY REJECTS (#351.52) file.

REJECT REPORT - Allows you to view all of the entries in the CHAMPUS PHARMACY REJECTS (#351.52) file and determine the reason(s) for the rejected entries.

RESUBMIT A CLAIM - Used to resubmit a transaction which was originally rejected by the FI (Fiscal Intermediary - the company with which a Tricare patient holds their Tricare insurance coverage).

REVERSE A CLAIM - Used to reverse or cancel a claim for a prescription that was submitted in error.

TRANSMISSION REPORT - Allows you to view a list of pharmacy transmissions for prescriptions which were filled during a specified date range.

PATIENT BILLING REPORTS MENU

PRINT CHECK-OFF SHEET FOR APPOINTMENTS - Allows you to print Ambulatory Surgery Check-Off Sheets by patient name or clinic for a specified appointment date.

PATIENT CURRENTLY CONT. HOSPITALIZED SINCE 1986 - Allows you to print a list (from the IB CONTINUOUS PATIENT file) of current inpatients continuously hospitalized at the same level of care since 1986.

PRINT IB ACTIONS BY DATE - Provides a list of the Integrated Billing actions for a specified date range.

EMPLOYER REPORT - Provides a listing of veteran's employers which may be used to confirm insurance coverage with those employers.

EPISODE OF CARE BILL LIST - Used to list all bills related to an episode of care.

ESTIMATE CATEGORY C CHARGES FOR AN ADMISSION - Used to estimate the Means Test/Category C charges for an episode of hospital or nursing home care for a proposed length of stay.

OUTPATIENT/REGISTRATION EVENTS REPORT - Designed to show potentially billable outpatient activity (i.e., scheduled appointments, add/edits, and registrations) and related billing activity for a date range.

HELD CHARGES REPORT - Provides a list of all charges with a status of ON HOLD.

PATIENT BILLING INQUIRY - Allows you to display/print information on any reimbursable insurance bill, pharmacy copay, or Means Test bill.

LIST ALL BILLS FOR A PATIENT - Used to print a list of all bills on file for a selected patient.

CATEGORY C BILLING ACTIVITY LIST - Used to list all Means Test/Category C charges within a specified date range.

THIRD PARTY OUTPUT MENU

VETERANS W/INSURANCE AND DISCHARGES - Used to produce a list of all patients who have reimbursable insurance and who were discharged from the medical center during a selected date range.

VETERAN PATIENT INSURANCE INFORMATION - Provides insurance information on veteran inpatients.

VETERANS W/INSURANCE AND INPATIENT ADMISSIONS - Used to produce a list of all patients who have reimbursable insurance and who had admissions to the medical center during a selected date range.

VETERANS W/INSURANCE AND OPT. VISITS - Used to produce a list of all patients who have reimbursable insurance and who had outpatient visits to the medical center during a selected date range.

PATIENT REVIEW DOCUMENT - Used to print the Third Party Review Form by patient name and admission date specifications.

INPATIENTS W/UNKNOWN OR EXPIRED INSURANCE - Allows you to print a list of veteran inpatients with no insurance, expiring insurance (expired or will expire within 30 days), or unknown insurance.

OUTPATIENTS W/UNKNOWN OR EXPIRED INSURANCE - Allows you to print a list of veteran outpatients with no insurance, expiring insurance (expired or will expire within 30 days), or unknown insurance for a specified date range.

SINGLE PATIENT CATEGORY C BILLING PROFILE - Provides a list of all Means Test/Category C charges within a specified date range for a selected patient.

CHECK OFF SHEET PRINT - Allows you to print Ambulatory Surgery Check-Off Sheets that have been set up through the Build CPT Check-off Sheet option.

THIRD PARTY JOINT INQUIRY - Provides information needed to answer questions from insurance carriers regarding specific bills or episodes of care.

THIRD PARTY BILLING MENU

PRINT BILL ADDENDUM SHEET - Used to print the addendum sheets that may accompany HCFA 1500 RX refill or prosthetic bills. The addendum contains information that could not fit on the bill form.

AUTHORIZE BILL GENERATION - Used to authorize the printing of third party bills and the release of the information to Fiscal Service.

ENTER/EDIT BILLING INFORMATION - Used to enter the information required to generate a third party bill and to edit existing billing information.

CANCEL BILL - Allows the user to cancel a bill at any point in the billing process.

COPY AND CANCEL - Used to cancel a bill, copy all the information into a new bill, and edit the new bill where necessary.

DELETE AUTO BILLER RESULTS - Used to delete entries from the Automated Biller Errors/Comments report prior to a user-selected date for any entry not associated with a bill.

PRINT BILL - Used to print third party bills on the appropriate form (UB-82, UB-92, or HCFA-1500) after all required information has been input and the billing record has been authorized.

PATIENT BILLING INQUIRY - Allows you to display/print information on any reimbursable insurance bill, pharmacy copay, or Means Test bill.

PRINT AUTO BILLER RESULTS - Used to print the Automated Biller Errors/Comments report.

PRINT AUTHORIZED BILLS - Print all authorized bills by user-specified order.

RETURN BILL MENU

EDIT RETURNED BILL - Used to correct bills with a status of RETURNED FROM AR (NEW) which have been returned to MAS from Accounts Receivable.

RETURNED BILL LIST - Prints a listing of all bills that have been returned to MAS from Accounts Receivable.

RETURN BILL TO A/R - Used to send bills which have been returned to MAS back to Accounts Receivable after they have been corrected.

UB-82 TEST PATTERN PRINT - Used to print a test pattern on the UB-82 billing form so that the form alignment in the printer can be checked.

UB-92 TEST PATTERN PRINT - Used to print a test pattern on the UB-92 billing form so that the form alignment in the printer can be checked.

HCFA-1500 TEST PATTERN PRINT - Allows you to print a test pattern on the HCFA-1500 form in order for the form alignment in the printer to be checked.

OUTPATIENT VISIT DATE INQUIRY - Allows you to display information on any outpatient insurance bill for a selected patient.

Enter/Edit Billing Information

When entering a patient name at the first prompt, a list of the patient's bills is provided. This list has been updated to include the types of charges on each bill: inpatient (institutional/ professional), opt visit date, prescription, CPT, and/or prosthetic.

When creating a new bill, a list of the bills for the patient that have the same event date as the new bill is provided. This list has been updated to include the types of charges on each bill: inpatient (institutional/professional), opt visit date, prescription, CPT, and/or prosthetic.

New help has been added to display the HCFA 1500 block 24. Enter "?HCFA" and a replica of how the claim will print on the HCFA 1500 block 24 will be displayed.

The automatic addition of charges to a bill has been updated to use the Charge Master rather than the old rates in the BILLING RATES file (#399.5).

A new edit check has been added when editing of the bill is complete. This edit check will provide a warning if the Patient Short Address on a UB-92 bill has been left blank. This is a warning only. This field is not required, so the bill may still be authorized.

If entering an inpatient bill, a non-covered amount (UB-92 form locator 48) can be entered for each revenue code you enter. This was requested as a way to report pass days and is an optional data element.

Screen 3

Form Type must now be a national/print form to be valid. You cannot enter a local form name here. (This field is only used to determine the general format of the bill, not what form prints).

If the bill has indicated secondary insurance, Primary Prior Payment data can be entered. If the bill has indicated tertiary insurance, Primary and Secondary Prior Payment data can be entered. (form locators 54a,b on the UB-92).

Enter/Edit Billing Information

On bills that have only Rx charges, the Prescription mailing address of the Primary Insurance Company will be used as the bill's mailing address. If the Insurance Company does not have a specific address for Rxs, then the Outpatient Mailing Address will be used.

Screens 4 and 5

When entering procedures, the DIVISION will only be asked if there may be CPT charges for the bill that are identified by region/locality of care. This is true if the procedures are being added manually or from Scheduling.

If there may be CPT based charges for the bill, then the bill's charges will be automatically recalculated if any CPTs are added/edited.

When adding prescriptions to the bill, if there is a site, DEFAULT RX REFILL CPT (#350.9,1.3); or a site, DEFAULT RX REFILL DX (#350.9,1.29), defined then they are automatically added to the bill. This has been updated so that if both of these exist, then the DEFAULT RX REFILL DX will be added as the ASSOCIATED DIAGNOSIS (1) (#399,304,10) for the site DEFAULT RX REFILL CPT.

The original prescription fill and all refills will be displayed for both types of CHAMPUS bills.

A new prompt, "CPT Modifier" appears when entering procedure information if the Procedure Coding Method entered is CPT-4.

Screen 6

When entering revenue code charges for inpatients, you can now enter a non-covered charge.

Screens 6 and 7

The first data set (option 1) has been updated with a new field, DEFAULT DIVISION. This field is Not Required. It will be used to determine if the bill falls within a particular Billing Region.

A new selection has been added, [6] Rate Schedule, to allow you to force a bills charges to be recalculated and to allow you to choose which charges to add to a bill. This will display all Rate Schedules and Charge Sets that have been assigned to the Rate Type and Bill Classification (Inpt/Opt) of the bill.

Enter/Edit Billing Information

When manually entering charges and revenue codes two new fields will be asked: TYPE and COMPONENT.

When entering charges and revenue codes, PROCEDURE will always be asked. This was only asked if the bill was a HCFA 1500.

When entering charges and revenue codes, the DIVISION will only be asked if there may be CPT charges based on location of care for the bill, and if a PROCEDURE has been entered.

Screen 9

New local screen, if defined for form type of bill (UB-92 or HCFA 1500).

 IB EDIT security key required to access this option.

Introduction

The Enter/Edit Billing Information option is used to enter the information required to generate a third party bill and to edit existing billing information. A new bill can be entered or an existing bill can be edited, as long as the existing bill has not been authorized or cancelled. Once a bill has been filed (billing record number established), it cannot be deleted. The bill can be cancelled through the Cancel Bill option.

If the selected patient's eligibility has not been verified and the ASK HINQ IN MCCR parameter is set to YES, the user will have the opportunity to enter a HINQ (Hospital Inquiry) request into the HINQ Suspense File. This request will be transmitted to the Veterans Benefits Administration to obtain the patient's eligibility information. If Means Test data such as category, Means Test last applied, and date Means Test completed is available, it will be displayed after the patient name or bill number has been entered.

When entering a new bill, the system will prompt for EVENT DATE. When billing for multiple outpatient visits, the date of the initial visit is used. For an inpatient bill, the date of the admission is used. If an interim bill is being issued, the EVENT DATE should be the date of admission for that episode of care.

Enter/Edit Billing Information

Introduction, cont.

The Medical Care Cost Recovery data is arranged so that it can be viewed and edited through various screens. The data is grouped into sections for editing. Each section is labeled with a number to the left of the data items. Data group numbers enclosed by brackets ([ ]) can be edited while those enclosed by arrows (< >) cannot. The patient's name, social security number, bill number, the bill classification (Inpatient or Outpatient) and the screen number appear at the top of every screen. A <?> entered at the prompt which appears at the bottom of every screen will provide you with a HELP SCREEN for that particular screen. The HELP SCREEN lists the data groups found on that screen and also provides the name and number of each available screen in the option.

SCREEN 1 - DEMOGRAPHIC INFORMATION
The Demographic Screen contains patient information such as date of birth, marital status, address, phone number (although the phone number is not displayed, it is included in Group 5) and whether or not the patient was service connected for any condition at the time the care on the bill was rendered. Much of this screen is automatically filled in from data in the PATIENT file. Users who do not hold the DG ELIGIBILITY security key will only be able to edit the alias, address, and patient short address prompts. The Patient Short Address prompt is for a shortened version of the patient's address if over 47 characters (to fit on the billing form).

SCREEN 2 - EMPLOYMENT INFORMATION
The Employment Screen lists the patient's employer, employer address, and his/her employment status. The spouse's employer may also be listed. Spouse's employment data will only be editable if the patient is married or separated.

SCREEN 3 - PAYER INFORMATION
Screen 3 contains information regarding rate type and who is responsible for payment of the bill; patient, insurer, or other. OTHER status may include another VA, a private hospital, etc. You can make a new entry to the INSTITUTION file from this screen.

The bill mailing address appears on this screen. Please see the Data Supplement at the end of this option documentation for important information on how this is determined.

Enter/Edit Billing Information

Introduction, cont.

When insurance companies are entered into the INSURANCE COMPANY file, the system prompts for whether or not this company will reimburse VA for the cost of the patient's care. Entry of an insurance company that has been designated as "will not reimburse" is not allowed at this screen. For bills where the payer is the insurance company and the patient has one insurance company that will reimburse the government, that company will be stored as the primary insurance company. Inactivating the insurance company has no effect on the insurance carriers associated with the bill.

Selection of insurance companies is limited to the primary, secondary, and tertiary insurance companies that are billable for the event date. A provider number can be entered for each of the three possible insurance carriers. This field will be loaded from the Hospital Provider Number if one has been entered for the insurance carrier.

Insurance company addresses can only be edited through the Insurance Company Entry/Edit option.

Any bill with a CHAMPVA rate type requires the primary insurance carrier to have a type of coverage defined as CHAMPVA; otherwise, the bill cannot be authorized.

If the MULTIPLE FORM TYPES site parameter is set to YES, a form type prompt will appear. The UB-82 and UB-92 are considered a single form, so for a site to have multiple forms they would have to use one of the UB forms and the HCFA-1500.

Changing the form type to HCFA-1500 will cause the CODING METHOD field to default to CPT-4 if it has not already been defined. Changing the primary insurance carrier or responsible institution will cause the revenue codes to be rebuilt and charges to be recalculated.

SCREEN 4 - EVENT INPATIENT INFORMATION

Screen 4 appears for inpatient bills only. This screen includes data concerning admission and discharge dates, principal diagnosis and procedures, prosthetics, and for accidents, the time the accident occurred. If the MCCR site parameter CAN CLERK ENTER NON-PTF CODES? is set to YES, diagnosis and procedure codes not found in the PTF record can be input into the billing record. Occurrence, condition, and value codes also appear on this screen.

Enter/Edit Billing Information

Introduction, cont.

A print order can be specified for each procedure/diagnosis entered. If no print order is specified, the procedures/diagnoses will print in the order entered. The six procedures and nine diagnoses with the lowest print order will be printed in the boxes on the form and the remainder will print as additional procedures/diagnoses.

SCREEN 5 - EVENT OUTPATIENT
Screen 5 appears for outpatient bills only. This screen displays data concerning the diagnosis, coding method, and outpatient procedure codes. The coding method must be specified before outpatient procedure codes can be entered/edited. Diagnosis coding is possible on this screen. Information concerning prosthetics and prescription refills is located here. The RX original fill date for bills with a rate type of CHAMPVA will now be displayed (if within the bill's date range.) Occurrence, condition, and value codes also appear on this screen.

If the MCCR site parameter USE OP CPT SCREEN is set to YES, the Current Procedural Terminology Code Screen will appear when editing procedure codes. The screen will list CPT codes for the dates associated with the bill.

An associated diagnosis (diagnosis responsible for the procedure being performed) must be entered for each procedure for HCFA-1500s. You can enter from 1 to 4 associated diagnoses. The associated diagnosis must match one of the first four diagnoses entered.

Adding a BASC procedure or an OP VISIT DATE will cause the revenue codes to be rebuilt and charges recalculated for both UB-82/92 and HCFA-1500 form types. Only one visit date is allowed on a UB-82/92 that also has BASC procedures. This restriction does not apply to HCFA-1500s.

A print order can be specified for each procedure/diagnosis entered. If no print order is specified, the procedures/diagnoses will print in the order entered. The six procedures and nine diagnoses with the lowest print order will be printed in the boxes on the form and the remainder will print as additional procedures/diagnoses.

If the TRANSFER PROCEDURES TO SCHED? parameter is set to YES, any ambulatory surgery entered on the bill can be transferred to the Scheduling Visits file and stored under a 900 stop code. An associated clinic must be entered for all procedures that are to be transferred to the SCHEDULING VISITS file.

Enter/Edit Billing Information

Introduction, cont.

SCREEN 6 & 7 - BILLING GENERAL INFORMATION
The Billing Screen appears differently for inpatient (Screen 6) and outpatient (Screen 7) episodes. Both screens include bill from and to dates, charges, bill type, time frame, covered and non-covered days, and assignment of benefits. If the billing period crosses fiscal or calendar years, two separate bills must be prepared (one for each fiscal/calendar year). Adding an OP VISIT DATE or entering the STATEMENT FROM and STATEMENT TO dates will cause the revenue codes to be rebuilt and charges to be recalculated for both UB-82/92 and HCFA-1500 forms.

Screen 6 also contains the discharge bedsection and length of stay (in days). The automatic length of stay calculation excludes the date of discharge. For interim first and interim continuous bills, each day is added to the length of stay so interim bills do not overlap. Screen 7 allows for input of outpatient visit dates, up to 30 visits per bill. Only one visit date is allowed on UB-82/92s that also have BASC procedures. This restriction does not apply to HCFA-1500s.

Revenue codes and rates are automatically calculated. You can add additional revenue codes. Each revenue code will be associated with a bedsection. To itemize a CHAMPVA outpatient bill, a CPT procedure code may be added to each revenue code on Screen 7.

When editing a sensitive record, (one which contains information pertaining to drugs, alcohol, sickle cell anemia, or other sensitive information), the user will be prompted for R.O.I. form. This field denotes whether or not release of information forms have been signed.

When entering an offset amount (amount to be subtracted from the total charges on the bill; i.e., copayment, deductible), entry of an offset description can also be entered.

When entering a third party bill (anything not billed to the patient), the ASSIGNMENT OF BENEFITS field will automatically be set to YES and cannot be edited.

Enter/Edit Billing Information

Introduction, cont.

SCREEN 8 - BILLING SPECIFIC INFORMATION
For UB-92 forms, this screen contains the bill remark, treatment authorization code, admitting diagnosis, attending and other physicians, and those locators on the billing form which are unlabeled (locator 49 is uneditable). The UB-82 form excludes specific fields for the admitting diagnosis and the physicians; however, they can be entered into the unlabeled form locators. For HCFA-1500 forms, this screen contains the unable to work from and to dates, Block 31 entry/edit, and treatment authorization code.

Several site parameters and two security keys affect the prompts which appear at the end of this option. Please see the Data Supplement at the end of this option documentation for an explanation of how these site parameters and security keys affect the option.

A mail group can be specified (through the site parameters) so that every time a bill is disapproved during the authorization phase of the billing process, all members of this group are notified via electronic mail. If this group is not specified, only the billing supervisor, the initiator of the billing record, and the user who disapproved the bill will be recipients of the message. An example of this message can be found in the Data Supplement.

The UB-82, UB-92, and HCFA-1500 billing forms are the output which can be produced from this option. The data elements and design of these forms has been determined by the National Uniform Billing Committee and has been adapted to meet the specific needs of the Department of Veterans Affairs. They must be generated (printed) at 80 characters per line at 10 pitch. Copies of the billing forms are included in the Print Bill option documentation.

The UB-82, UB-92, and HCFA-1500 billing forms are the output which may be produced from this option. The data elements and design of these forms has been determined by the National Uniform Billing Committee and has been adapted to meet the specific needs of the Department of Veterans Affairs. They must be generated (printed) at 80 characters per line at 10 pitch. Copies of the billing forms are included in the Print Bill option documentation.

Enter/Edit Billing Information

Example 1 - Inpatient Bill

```
Enter BILL NUMBER or PATIENT NAME:    JACKSON,SALLY          02-09-60     208442336
YES     SC VETERAN

                          *** WARNING ***
                     *** RESTRICTED RECORD ***
                *** ELIGIBILITY NOT VERIFIED ***

Patient Requires a Means Test
Primary Means Test Required from ''

  1   OCT 4,1996         K700020  REIM INS-Opt              ENTERED
  2   OCT 3,1996         K700019  REIM INS-Opt              ENTERED
  3   OCT 1,1996         K700016  REIM INS-Inpt             ENTERED
  4   OCT 1,1996         K700017  REIM INS-Opt              ENTERED
  5   OCT 1,1996         K700018  REIM INS-Opt              ENTERED

PRESS <RETURN> TO CONTINUE, OR
CHOOSE 1-5:  ^

DO YOU WANT TO ESTABLISH A NEW BILLING RECORD FOR ' JACKSON,SALLY '? No//      y  (Yes)
   BILLING LOCATION OF CARE: 1//    1  HOSPITAL (INCLUDES CLINIC) - INPT. OR OPT.
BILLING BILL CLASSIFICATION:    1  INPATIENT (MEDICARE PART A)
   BILLING TIMEFRAME OF BILL:    1  ADMIT THRU DISCHARGE CLAIM
   BILLING IS THIS A SENSITIVE RECORD?: NO//     NO  (NO)
   BILLING RATE TYPE:    reiMBURSABLE INS.       Who's Responsible: INSURER
    Select INPATIENT EVENT (ADMISSION) DATE:
        1   JAN 23,1996@16:18:06        2   AUG 22,1994@13:09:55
        3   AUG 16,1994@13:00           4   APR 2,1994@15:00
        5   MAR 31,1994@12:00           6   JAN 21,1994@19:42:24
        7   JAN 13,1994@22:22:30        8   NOV 15,1993@13:03:01
        9   MAR 3,1993@13:00            10   JUL 5,1990@10:38
    OR
    Select NON-VA INPATIENT EVENT (ADMISSION) DATE:
        11   DEC 17,1991                12   JUL 9,1994@09:00
        13   JUL 25,1994                14   AUG 14,1994

    CHOOSE 1-14 or Enter DATE:     1
    PTF record indicates 0 of 1 movements are for Service Connected Care.

  Insurance Co.     Subscriber ID     Group       Holder  Effectve Expires  Only
  ================================================================================
  NEW HEALTH        9999              Ind. Plan   SPOUSE  08/04/93 05/31/94
  BC/BS OF ALBANY   208442336                     SELF    07/01/94
  ABC               SI333             HJKJ        SELF    11/12/94
```

Enter/Edit Billing Information

Example 1 - Inpatient Bill, cont.

```
JACKSON,SALLY   208-44-2336   BILL#: K700059 - Inpatient            SCREEN <6>
================================================================================
                          BILLING - GENERAL INFORMATION
[1] Bill Type   : 111               Timeframe: ADMIT THRU DISCHARGE
    Covered Days: UNSPECIFIED Non-Covered Days: UNSPECIFIED
    Division    :
[2] Sensitive?  : NO               Assignment: YES
[3] Bill From   : JAN 23, 1996        Bill To: SEP 30, 1996
[4] Bedsection  : UNSPECIFIED
    LOS         : 251
[5] Rev. Code   : 101-ALL INCL R&B             $150,098.00  GENERAL MEDICAL
    Rev. Code   : 240-ALL INCL ANCIL            $63,252.00  GENERAL MEDICAL
    Rev. Code   : 960-PRO FEE                   $29,116.00  GENERAL MEDICAL
    OFFSET      :       $0.00   [NO OFFSET RECORDED]
    BILL TOTAL  : $242,466.00
    FY 1        : 96                  Charges: $242,466.00
[6] Rate Sched  : (re-calculate charges)


<RET> to CONTINUE, 1-6 to EDIT, '^N' for screen N, or '^' to QUIT:      1
TIMEFRAME OF BILL: ADMIT THRU DISCHARGE CLAIM//     <RET>
COVERED DAYS:  8
NON-COVERED DAYS:  1
DEFAULT DIVISION:  <RET>

JACKSON,SALLY   208-44-2336   BILL#: K700059 - Inpatient            SCREEN <6>
================================================================================
                          BILLING - GENERAL INFORMATION
[1] Bill Type   : 111               Timeframe: ADMIT THRU DISCHARGE
    Covered Days: 8           Non-Covered Days: 1
    Division    :
[2] Sensitive?  : NO               Assignment: YES
[3] Bill From   : JAN 23, 1996        Bill To: SEP 30, 1996
[4] Bedsection  : UNSPECIFIED
    LOS         : 251
[5] Rev. Code   : 101-ALL INCL R&B             $150,098.00  GENERAL MEDICAL
    Rev. Code   : 240-ALL INCL ANCIL            $63,252.00  GENERAL MEDICAL
    Rev. Code   : 960-PRO FEE                   $29,116.00  GENERAL MEDICAL
    OFFSET      :       $0.00   [NO OFFSET RECORDED]
    BILL TOTAL  : $242,466.00
    FY 1        : 96                  Charges: $242,466.00
[6] Rate Sched  : (re-calculate charges)


<RET> to CONTINUE, 1-6 to EDIT, '^N' for screen N, or '^' to QUIT:      <RET>
```

Enter/Edit Billing Information

Example 2 - Outpatient Bill

```
Enter BILL NUMBER or PATIENT NAME:       K700018       JACKSON,SALLY     10-01-96
    Outpatient     REIMBURSABLE INS.     ENTERED/NOT REVIEWED
                *** ELIGIBILITY NOT VERIFIED ***

Patient Requires a Means Test
Primary Means Test Required from ''


JACKSON,SALLY   208-44-2336   BILL#: K700018 - Outpatient           SCREEN <1>
================================================================================
                              DEMOGRAPHIC INFORMATION
[1] DOB    : FEB 9,1960
[2] Alias  : NO ALIAS ON FILE
[3] Sex    : FEMALE                    Marital: NEVER MARRIED
[4] Veteran: YES                   Eligibility: SC, LESS THAN 50%

[5] Address: 415 SUMMER STREET       Temporary: NO TEMPORARY ADDRESS
SUMMERVILLE, PA 15221

[6] Pt Short
    Address: 415 SUMMER STREET,APT #10,SUMMERVILLE,PA 15221

[7] SC Care: YES  (Enter '7' to list disabilities)



<RET> to CONTINUE, 1-7 to EDIT, '^N' for screen N, or '^' to QUIT:      <RET>


JACKSON,SALLY   208-44-2336   BILL#: K700018 - Outpatient           SCREEN <2>
================================================================================
                              EMPLOYMENT INFORMATION
[1] Employer: MACY'S           <2> Spouse's: UNSPECIFIED
              STREET ADDRESS UNKNOWN
              CITY/STATE UNKNOWN
       Phone: UNSPECIFIED
  Occupation: SALES PERSON
      Status: RETIRED



<RET> to CONTINUE, 1-2 to EDIT, '^N' for screen N, or '^' to QUIT:      <RET>
```

Enter/Edit Billing Information

Example 2 - Outpatient Bill, cont.

```
JACKSON,SALLY    208-44-2336   BILL#: K700018 - Outpatient           SCREEN <5>
================================================================================
                          EVENT - OUTPATIENT INFORMATION
<1> Event Date : OCT 01, 1996
[2] Prin. Diag.: UNSPECIFIED [NOT REQUIRED]
[3] OP Visits  : OCT 1,1996, OCT 2,1996, OCT 4,1996,
[4] Cod. Method: UNSPECIFIED [NOT REQUIRED]
[5] Rx. Refills: UNSPECIFIED [NOT REQUIRED]
[6] Pros. Items: UNSPECIFIED [NOT REQUIRED]
[7] Occ. Code  : UNSPECIFIED [NOT REQUIRED]
[8] Cond. Code : UNSPECIFIED [NOT REQUIRED]
[9] Value Code : UNSPECIFIED [NOT REQUIRED]



<RET> to CONTINUE, 1-9 to EDIT, '^N' for screen N, or '^' to QUIT:      <RET>
```

```
JACKSON,SALLY    208-44-2336   BILL#: K700018 - Outpatient           SCREEN <7>
================================================================================
                          BILLING - GENERAL INFORMATION
[1] Bill Type   : 131               Timeframe: ADMIT THRU DISCHARGE
    Covered Days: UNSPECIFIED          Division:
    Non-Cov Days: UNSPECIFIED        Disch Stat:
[2] Sensitive?  : NO               Assignment: YES
[3] Bill From   : OCT 01, 1996        Bill To: OCT 04, 1996
[4] OP Visits   : OCT 1,1996, OCT 2,1996, OCT 4,1996,
[5] Rev. Code   : 500-OUTPATIENT SVS               $582.00  OUTPATIENT VISIT
    OFFSET      :       $0.00   [NO OFFSET RECORDED]
    BILL TOTAL  :     $582.00
    FY 1        : 97                  Charges:     $582.00
[6] Rate Sched  : (re-calculate charges)


<RET> to CONTINUE, 1-5 to EDIT, '^N' for screen N, or '^' to QUIT:      <RET>
```

```
JACKSON,SALLY   208-44-2336   BILL#: K700018 - Outpatient           SCREEN <8>
================================================================================
                          BILLING - SPECIFIC INFORMATION
[1] Bill Remark     : UNSPECIFIED [NOT REQUIRED]
    Tx Auth. Code   : UNSPECIFIED [NOT REQUIRED]
    Admitting Dx    : UNSPECIFIED [NOT REQUIRED]
[2] Attending Phy.  : UNSPECIFIED [NOT REQUIRED]
    Other Physician : UNSPECIFIED [NOT REQUIRED]
[3] Form Locator 2  : UNSPECIFIED [NOT REQUIRED]
    Form Locator 11 : UNSPECIFIED [NOT REQUIRED]
[4] Form Locator 31 : UNSPECIFIED [NOT REQUIRED]
    Form Locator 37 : UNSPECIFIED [NOT REQUIRED]
[5] Form Locator 56 : UNSPECIFIED [NOT REQUIRED]
    Form Locator 57 : UNSPECIFIED [NOT REQUIRED]
    Form Locator 78 : UNSPECIFIED [NOT REQUIRED]


<RET> to CONTINUE, 1-5 to EDIT, '^N' for screen N, or '^' to QUIT:      <RET>
```

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Automated Means Test Billing Menu
Cancel/Edit/Add Patient Charges

The Add a Charge action has been enhanced to allow you to add CHAMPUS copayment charges for prescriptions, inpatient care, and outpatient care. Three new Charge Types have been added to correspond to these types of charges.

 IB AUTHORIZE security key is required to access this option.

Introduction

The Cancel/Edit/Add Patient Charges option allows you to manually cancel, edit, or add per diem and copayment patient charges or fee services for a specified patient and date range. When a charge is edited, the original charge is canceled and a new charge is added. Once added or edited, the charges are passed to Accounts Receivable. You may receive Accounts Receivable mail messages when editing/canceling through this option.

You cannot add medication copayment charges for patients determined to be exempt from the medication copayment requirement.

You can choose whether or not to include pharmacy copay charges. Only pharmacy charges which have been added through this option can be edited or deleted through this option.

You can also choose to bill CHAMPVA inpatient subsistence charges for past admissions. (Current and future admissions will be billed automatically at discharge.) The CHAMPVA inpatient subsistence charge may be canceled through this option, but it will be canceled **only** in IB. You **must** go into the AR module to decrease the receivable to zero ($0).

Charges are displayed for the specified patient and date range and several "actions" can be taken against these charges. You can add/edit/cancel a charge, pass a charge to Accounts Receivable, change to another patient or date range, update an event by changing the event status, or change the date used to record the last date for which Means Test charges were billed for the admission.

List Manager actions are also available (i.e., First Screen, Last Screen, Up a Line, Down a Line, etc.). If you need help in using the List Manager functionality, please refer to the Appendix of this user manual.

Automated Means Test Billing Menu
Cancel/Edit/Add Patient Charges

Introduction, cont.

Once action has been taken on a charge, the screen is redisplayed showing the new data. If you have edited a charge, the status of the original entry is changed to CANCELLED, and two new entries are added. The first entry offsets the original charge (the amount appears in parentheses indicating a credit) and the new charge is shown.

Charges added or edited through this option are added/edited to the INTEGRATED BILLING ACTION file (#350). When adjustments are made through this option which affect the number of inpatient days or inpatient amount, you are prompted to choose whether or not you wish to make the adjustment to the Means Test Billing Clock.

Example

```
Select PATIENT NAME:  AIELLO,FRANK        04-23-13     134097714    NO     NSC
Search for CHARGES from: NOV  5, 1992//   <RET>  (NOV 05, 1992)
                      to: NOV  5, 1993//   <RET>  (NOV 05, 1993)
Include RX COPAY charges? NO//   <YES>
```

```
Charges                      Nov 05, 1993 10:19:52          Page:    1 of    1
Cancel/Edit/Add Charges                                  11/05/92 THRU 11/05/93
Patient: AIELLO,FRANK A7714
   Bill From  Bill To   Charge Type              Bill #  Status        Charge
1  12/12/92   12/12/92  OPT COPAY NEW                    ON HOLD        $33
2  02/01/93   02/21/93  INPT PER DIEM NEW        L10525  BILLED         $210
3  02/01/93   02/01/93  INPT COPAY (NEU) NEW     L10524  BILLED         $676
4  06/15/93   06/19/93  INPT PER DIEM NEW        L10525  BILLED         $50
5  10/12/93   10/12/93  OPT COPAY NEW            L10690  BILLED         $33
6  11/02/93   11/02/93  PSO NSC RX COPAY NEW     M10042  CANCELLED      $2
7  11/02/93   11/02/93  PSO NSC RX COPAY CANCEL  M10042  BILLED        ($2)

          Enter ?? for more actions
AC  Add a Charge          CP  Change Patient        UE  Update Event
EC  Edit a Charge         CD  Change Date Range
CC  Cancel a Charge       PC  Pass a Charge
Select Action: Quit//  EC=2   Edit a Charge
```

Automated Means Test Billing Menu
Cancel/Edit/Add Patient Charges

Example, cont.

```
                          E D I T   A   C H A R G E
                            Processing Charge #2
------------------------------------------------------------------------------
   Name: AIELLO,FRANK                    Type: INPT PER DIEM NEW
     ID: 134-09-7714                      Amt: $210 (BILLED)
------------------------------------------------------------------------------

Select EDIT REASON:  14  ELIGIBILITY INCORRECT        14

  ** Active Billing Clock **
  Begin Date: 02/01/93   # Inpt Days: 26   1st 90 days: $676


Charge for services from: FEB  1, 1993//    <RET>  (FEB 01, 1993)
  Charge for services to: FEB 21, 1993//    2 20 93  (FEB 20, 1993)

New charge to be billed: $200


Okay to edit this charge?  Y  YES

Building the cancellation transaction...  .. done.

Building the updated transaction... done.

Means Test Billing Clock information for AIELLO,FRANK (7714)
------------------------------------------------------------------------------
  Clock Start Date: 02/01/93              Clock End Date: N/A
      Clock Status: CURRENT               Inpatient Days: 26

  Medicare Deductible Co-payments:
               1st 90 days: $676             3rd 90 days: $0
               2nd 90 days: $0               4th 90 days: $0
------------------------------------------------------------------------------

Update the number of inpatient days from 26 to 25?    Y  YES
The clock has been updated.

Press RETURN to process the next charge or to return to the list:     <RET>
Rebuilding list of charges...
```

Automated Means Test Billing Menu
Cancel/Edit/Add Patient Charges

Example, cont.

```
Charges                        Nov 05, 1993 10:19:52          Page:    1 of    1
Cancel/Edit/Add Charges                                       11/05/92 THRU 11/05/93
Patient: AIELLO,FRANK A7714
   Bill From  Bill To   Charge Type              Bill #  Status        Charge
1  12/12/92   12/12/92  OPT COPAY NEW                   ON HOLD        $33
2  02/01/93   02/21/93  INPT PER DIEM NEW       L10525  CANCELLED      $210
3  02/01/93   02/01/93  INPT COPAY (NEU) NEW    L10524  BILLED         $676
4  02/01/93   02/21/93  INPT PER DIEM CANCEL    L10525  UPDATED       ($210)
5  02/01/93   02/20/93  INPT PER DIEM UPDATE    L10525  BILLED         $200
6  06/15/93   06/19/93  INPT PER DIEM NEW       L10525  BILLED         $50
7  10/12/93   10/12/93  OPT COPAY NEW           L10690  BILLED         $33
8  11/02/93   11/02/93  PSO NSC RX COPAY NEW    M10042  CANCELLED      $2
9  11/02/93   11/02/93  PSO NSC RX COPAY CANCEL M10042  BILLED        ($2)

          Enter ?? for more actions
AC  Add a Charge          CP  Change Patient        UE  Update Event
EC  Edit a Charge         CD  Change Date Range
CC  Cancel a Charge       PC  Pass a Charge
Select Action: Quit//
```

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Automated Means Test Billing Menu
On Hold Menu
Send Converted Charges to A/R

EXAMPLE
The following example shows what might appear on your screen while using this option. User responses are shown in boldface type.

```
Pass converted charges by Patient or by Date (P/D):    P

This option is used to pass Means Test/Category C charges which have been
converted. Please enter a patient with converted charges and these
charges will be displayed and may be selected to be released to Accounts
Receivable.

Select PATIENT NAME:  KAGAN,PETER       10-10-25     112101011     NSC VETERAN

KAGAN,PETER      Pt ID: 112-10-1011
--------------------------------------------------------------------------------

The following IB Actions for this patient, are CONVERTED CHARGES:
================================================================================
 REF   Action ID  Bill Type                  From      To        Charge
================================================================================
  1       500466  OUTPATIENT COPAY        11/02/90  11/02/90     26.00
  2       500575  OUTPATIENT COPAY        01/09/91  01/09/91     20.00

Select IB Actions (REF #) to pass (or '^' to exit):    1,2
OK to pass these charges to Accounts Receivable: YES//    <RET>

Passing charges to Accounts Receivable...

================================================================================
                                          Bill # or
 REF   Action ID  Bill Type               On Hold    From       To      Charge
================================================================================
  1       500466  OUTPATIENT COPAY        On Hold  11/02/90  11/02/90    26.00
  2       500575  OUTPATIENT COPAY        On Hold  01/09/91  01/09/91    20.00

The charges listed above have been passed to Accounts Receivable.

* Please note that charges placed 'On Hold' are still pending release from
  Integrated Billing.

Select Another Patient: YES//   <RET>

Select PATIENT NAME:
```

Automated Means Test Billing Menu
On Hold Menu
Release Charges 'Pending Review'

In the heading of the Held Charges List, an indicator is displayed if the veteran is service connected.

Introduction

The Release Charges 'Pending Review' option is used to review charges which have been created when an Income Verification Match (IVM) verified Means Test has been received and filed at the medical facility. If such a Means Test results in changing the patient's Means Test status from Category A to Category C, copayment and per diem charges for previous episodes of care will automatically be created. The charges will not be automatically passed to Accounts Receivable but will be held in Billing until a review of the charges is complete. A mail message is sent to the Category C Billing mail group notifying users that the charges have been created and are pending review.

After review, you may pass the charges to Accounts Receivable for billing or cancel the charges. If passed to AR, the billing information will also be passed to the IVM software which will in turn transmit it to the IVM Center in Atlanta.

Since the billing clock was updated when the charge was originally built, you may need to update the billing clock if the charge is canceled. This can be accomplished through the Patient Billing Clock Maintenance option.

Automated Means Test Billing Menu
On Hold Menu
Release Charges 'Pending Review'

Example 1 - Cancel Charge

```
Patient List                Aug 04, 1994 07:30:20          Page:    1 of    1
Release Charges 'Pending Review'
                                                 Date of     Current       Active
    Patient Name                          Pt ID  Ver. MT     MT Cat.       Ins?
1   WILLIS,KATIE                          W5424  04/11/93    REQUIRED      NO
2   ZONICH,PAUL                           Z8877  06/14/93    REQUIRED      NO


          Enter ?? for more actions
SP  Select Patient
Select Action: Quit//  SP   Select Patient
Select Patient(s):  (1-2): 1
Generating a list of pending charges for WILLIS,KATIE ...


Held Charge List            Aug 04, 1994 07:34:22          Page:    1 of    1
Release Charges 'Pending Review'                    List of all Pending Charges
Patient: WILLIS,KATIE  W5424   **SC VETERAN**                          Date
   Bill From   Bill To     Charge Type                  Charge         Created
1  06/13/93    06/13/93    OPT COPAY NEW                $36            07/28/94


          Enter ?? for more actions
PC  Pass Charge           CC  Cancel Charge
Select Action: Quit//  CC   Cancel Charge
Select CANCELLATION REASON:   4  ENTERED IN ERROR        4

Okay to cancel this charge?  YES
Charge #1 has been canceled.

Means Test Billing Clock information for WILLIS,KATIE (5424)
------------------------------------------------------------------------------
  Clock Start Date: 06/13/93              Clock End Date: N/A
      Clock Status: CURRENT               Inpatient Days: 0

  Medicare Deductible Co-payments:
               1st 90 days: $0               3rd 90 days: $0
               2nd 90 days: $0               4th 90 days: $0
------------------------------------------------------------------------------

Since the billing clock was updated when the charge was originally built,
you may now need to update this clock since the charge has been canceled.
```

Automated Means Test Billing Menu
On Hold Menu
Release Charges 'Pending Review'

Example 1 - Cancel Charge, cont.

```
Press RETURN to continue or '^' to exit:    <RET>


Held Charge List            Aug 04, 1994 07:34:45          Page:    1 of    1
Release Charges 'Pending Review'                    List of all Pending Charges
Patient: WILLIS,KATIE  W5424                                          Date
   Bill From   Bill To     Charge Type                    Charge      Created

  There are no charges pending review for this patient.


          Enter ?? for more actions
PC  Pass Charge           CC  Cancel Charge
Select Action: Quit//  <RET>   QUIT
```

```
Patient List                Aug 04, 1994 07:35:22          Page:    1 of    1
Release Charges 'Pending Review'
                                                 Date of     Current       Active
    Patient Name                        Pt ID    Ver. MT     MT Cat.        Ins?
1   ZONICH,PAUL                         Z8877    06/14/93    REQUIRED       NO


          Enter ?? for more actions
SP  Select Patient
Select Action: Quit//  <RET>   QUIT
```

Example 2 - Pass Charge

```
Patient List                Aug 04, 1994 07:30:20          Page:    1 of    1
Release Charges 'Pending Review'
                                                 Date of     Current       Active
    Patient Name                        Pt ID    Ver. MT     MT Cat.        Ins?
1   WILLIS,KATIE                        W5424    04/11/93    REQUIRED       NO


          Enter ?? for more actions
SP  Select Patient
Select Action: Quit//  SP   Select Patient
Generating a list of pending charges for WILLIS,KATIE ...
```

Automated Means Test Billing Menu
On Hold Menu
Release Charges 'Pending Review'

Example 2 - Pass Charge

```
Held Charge List            Aug 04, 1994 07:34:22          Page:    1 of    1
Release Charges 'Pending Review'                    List of all Pending Charges
Patient: WILLIS,KATIE  W5424
                                                                        Date
   Bill From   Bill To     Charge Type                    Charge      Created
1  06/13/93    06/13/93    OPT COPAY NEW                  $36         07/28/94


          Enter ?? for more actions
PC  Pass Charge           CC  Cancel Charge
Select Action: Quit//  PC   Pass Charge

Okay to pass this charge?  YES
Charge #1 has been passed to Accounts Receivable.

Press RETURN to continue or '^' to exit:    <RET>
```

```
Held Charge List            Aug 04, 1994 07:34:45          Page:    1 of    1
Release Charges 'Pending Review'                    List of all Pending Charges
Patient: WILLIS,KATIE  W5424
                                                                        Date
   Bill From   Bill To     Charge Type                    Charge      Created

  There are no charges pending review for this patient.


          Enter ?? for more actions
PC  Pass Charge           CC  Cancel Charge
Select Action: Quit//  <RET>   QUIT
```

```
Patient List                Aug 04, 1994 07:35:22          Page:    1 of    1
Release Charges 'Pending Review'
                                                 Date of     Current       Active
    Patient Name                        Pt ID    Ver. MT     MT Cat.        Ins?

  There are no patients with charges pending review.


          Enter ?? for more actions
SP  Select Patient
Select Action: Quit//  <RET>   QUIT
```

Automated Means Test Billing Menu
On Hold Menu
Release Charges Awaiting New Copay Rate

INTRODUCTION

The Release Charges Awaiting New Copay Rate option is used to release charges which have been placed on hold because the outpatient copay rate is over one year old.

New billing rates are scheduled to be released from VA Central Office at the beginning of each fiscal year (10/1). However, there may be a delay in the release of these new rates. If the rate on file for the Means Test outpatient copayment charge is over one year old at the time the bill is created, these charges will be held until the new copay rate is entered. When the rate is entered, you are given the opportunity to release the charges to Accounts Receivable at that time or they can be released through this option. You will be prompted to task off a job which will automatically update the dollar amount and bill all such charges. The user will receive a message when the tasked job has completed.

If the copay rate currently in your Billing Table is too old to use, the following message will appear.

"The current copay rate (effective {date}) is still too old to use. Please be sure that you have entered the most current rate in your Billing Rates table."

Due to the brevity of this option, a process chart has not been provided.

Patient Billing Reports Menu
Outpatient/Registration Events Report

This report has been modified to indicate whether a patient is service connected, and whether a specific outpatient encounter was related to the patient's service connected condition.

Introduction

In Integrated Billing V. 1.5, the Outpatient/Registration Events Report was used primarily to list potentially billable outpatient activity (for Category C veterans) for the purpose of billing charges that were not automatically billable by the system. As IB V. 2.0 completes the automation of Means Test billing for all outpatient activity, this report becomes a validation tool.

This option lists all episodes of outpatient care for Category C veterans within a user specified date range; appointments, stop codes, and registrations. For each visit, the clinic, appointment time, type, and status are provided. Clinics with a default type of "research" are flagged on the report to assist sites in determining if regular appointments are being scheduled in clinics where the primary intent is research. For each patient listed, the report indicates whether the patient has claimed exposure to Agent Orange, ionizing radiation, or environmental contaminants and whether the patient has active insurance. If exposure is claimed, the responses to the Classification questions answered during the checkout process are displayed. Any charges associated with the episode of care are included.

A separate page will print for each date within the date range; therefore, you may wish to limit the date range selected. You may also wish to run this report during off hours, as it may be quite time consuming.

Example

```
Category C Outpatient and Registration Activity for 03/03/97
                              Printed: 05/30/97                    Page: 1

Patient/Event       Time  Clinic/Stop       Appt.Type          (Status)

ALLEN,ARTHUR A3363    [SC]    **Insured**
     CLINIC APPT    08:00 DERMATOLOGY       REGULAR            CHECKED OUT
      Care related to SC? YES


Enter RETURN to continue or '^' to exit:
```

Third Party Billing Menu
Enter/Edit Billing Information

When entering a patient name at the first prompt, a list of the patient's bills is provided. This list has been updated to include the types of charges on each bill: inpatient (institutional/ professional), opt visit date, prescription, CPT, and/or prosthetic.

When creating a new bill, a list of the bills for the patient that have the same event date as the new bill is provided. This list has been updated to include the types of charges on each bill: inpatient (institutional/professional), opt visit date, prescription, CPT, and/or prosthetic.

New help has been added to display the HCFA 1500 block 24. Enter "?HCFA" and a replica of how the claim will print on the HCFA 1500 block 24 will be displayed.

The automatic addition of charges to a bill has been updated to use the Charge Master rather than the old rates in the BILLING RATES file (#399.5).

A new edit check has been added when editing of the bill is complete. This edit check will provide a warning if the Patient Short Address on a UB-92 bill has been left blank. This is a warning only. This field is not required, so the bill may still be authorized.

If entering an inpatient bill, a non-covered amount (UB-92 form locator 48) can be entered for each revenue code you enter. This was requested as a way to report pass days and is an optional data element.

Screen 3

Form Type must now be a national/print form to be valid. You cannot enter a local form name here. (This field is only used to determine the general format of the bill, not what form prints).

If the bill has indicated secondary insurance, Primary Prior Payment data can be entered. If the bill has indicated tertiary insurance, Primary and Secondary Prior Payment data can be entered. (form locators 54a,b on the UB-92).

On bills that have only Rx charges, the Prescription mailing address of the Primary Insurance Company will be used as the bill's mailing address. If the Insurance Company does not have a specific address for Rxs, then the Outpatient Mailing Address will be used.

Screens 4 and 5

When entering procedures, the DIVISION will only be asked if there may be CPT charges for the bill that are identified by region/locality of care. This is true if the procedures are being added manually or from Scheduling.

If there may be CPT based charges for the bill, then the bill's charges will be automatically recalculated if any CPTs are added/edited.

When adding prescriptions to the bill, if there is a site, DEFAULT RX REFILL CPT (#350.9,1.3); or a site, DEFAULT RX REFILL DX (#350.9,1.29), defined then they are automatically added to the bill. This has been updated so that if both of these exist, then the DEFAULT RX REFILL DX will be added as the ASSOCIATED DIAGNOSIS (1) (#399,304,10) for the site DEFAULT RX REFILL CPT.

The original prescription fill and all refills will be displayed for both types of CHAMPUS bills.

A new prompt, "CPT Modifier" appears when entering procedure information if the Procedure Coding Method entered is CPT-4.

Screen 6

When entering revenue code charges for inpatients, you can now enter a non-covered charge.

Screens 6 and 7

The first data set (option 1) has been updated with a new field , DEFAULT DIVISION. This field is Not Required. It will be used to determine if the bill falls within a particular Billing Region.

A new selection has been added, [6] Rate Schedule, to allow you to force a bills charges to be recalculated and to allow you to choose which charges to add to a bill. This will display all Rate Schedules and Charge Sets that have been assigned to the Rate Type and Bill Classification (Inpt/Opt) of the bill.

Third Party Billing Menu
Enter/Edit Billing Information

When manually entering charges and revenue codes two new fields will be asked: TYPE and COMPONENT.

When entering charges and revenue codes, PROCEDURE will always be asked. This was only asked if the bill was a HCFA 1500.

When entering charges and revenue codes, the DIVISION will only be asked if there may be CPT charges based on location of care for the bill, and if a PROCEDURE has been entered.

Screen 9

New local screen, if defined for form type of bill (UB-92 or HCFA 1500).

 IB EDIT security key required to access this option.

Introduction

The Enter/Edit Billing Information option is used to enter the information required to generate a third party bill and to edit existing billing information. A new bill can be entered or an existing bill can be edited, as long as the existing bill has not been authorized or cancelled. Once a bill has been filed (billing record number established), it cannot be deleted. The bill can be cancelled through the Cancel Bill option.

If the selected patient's eligibility has not been verified and the ASK HINQ IN MCCR parameter is set to YES, the user will have the opportunity to enter a HINQ (Hospital Inquiry) request into the HINQ Suspense File. This request will be transmitted to the Veterans Benefits Administration to obtain the patient's eligibility information. If Means Test data such as category, Means Test last applied, and date Means Test completed is available, it will be displayed after the patient name or bill number has been entered.

When entering a new bill, the system will prompt for EVENT DATE. When billing for multiple outpatient visits, the date of the initial visit is used. For an inpatient bill, the date of the admission is used. If an interim bill is being issued, the EVENT DATE should be the date of admission for that episode of care.

Third Party Billing Menu
Enter/Edit Billing Information

Introduction, cont.

The Medical Care Cost Recovery data is arranged so that it can be viewed and edited through various screens. The data is grouped into sections for editing. Each section is labeled with a number to the left of the data items. Data group numbers enclosed by brackets ([ ]) can be edited while those enclosed by arrows (< >) cannot. The patient's name, social security number, bill number, the bill classification (Inpatient or Outpatient) and the screen number appear at the top of every screen. A <?> entered at the prompt which appears at the bottom of every screen will provide you with a HELP SCREEN for that particular screen. The HELP SCREEN lists the data groups found on that screen and also provides the name and number of each available screen in the option.

SCREEN 1 - DEMOGRAPHIC INFORMATION
The Demographic Screen contains patient information such as date of birth, marital status, address, phone number (although the phone number is not displayed, it is included in Group 5) and whether or not the patient was service connected for any condition at the time the care on the bill was rendered. Much of this screen is automatically filled in from data in the PATIENT file. Users who do not hold the DG ELIGIBILITY security key will only be able to edit the alias, address, and patient short address prompts. The Patient Short Address prompt is for a shortened version of the patient's address if over 47 characters (to fit on the billing form).

SCREEN 2 - EMPLOYMENT INFORMATION
The Employment Screen lists the patient's employer, employer address, and his/her employment status. The spouse's employer may also be listed. Spouse's employment data will only be editable if the patient is married or separated.

SCREEN 3 - PAYER INFORMATION
Screen 3 contains information regarding rate type and who is responsible for payment of the bill; patient, insurer, or other. OTHER status may include another VA, a private hospital, etc. You can make a new entry to the INSTITUTION file from this screen.

The bill mailing address appears on this screen. Please see the Data Supplement at the end of this option documentation for important information on how this is determined.

Third Party Billing Menu
Enter/Edit Billing Information

Introduction, cont.

When insurance companies are entered into the INSURANCE COMPANY file, the system prompts for whether or not this company will reimburse VA for the cost of the patient's care. Entry of an insurance company that has been designated as "will not reimburse" is not allowed at this screen. For bills where the payer is the insurance company and the patient has one insurance company that will reimburse the government, that company will be stored as the primary insurance company. Inactivating the insurance company has no effect on the insurance carriers associated with the bill.

Selection of insurance companies is limited to the primary, secondary, and tertiary insurance companies that are billable for the event date. A provider number can be entered for each of the three possible insurance carriers. This field will be loaded from the Hospital Provider Number if one has been entered for the insurance carrier.

Insurance company addresses can only be edited through the Insurance Company Entry/Edit option.

Any bill with a CHAMPVA rate type requires the primary insurance carrier to have a type of coverage defined as CHAMPVA; otherwise, the bill cannot be authorized.

If the MULTIPLE FORM TYPES site parameter is set to YES, a form type prompt will appear. The UB-82 and UB-92 are considered a single form, so for a site to have multiple forms they would have to use one of the UB forms and the HCFA-1500.

Changing the form type to HCFA-1500 will cause the CODING METHOD field to default to CPT-4 if it has not already been defined. Changing the primary insurance carrier or responsible institution will cause the revenue codes to be rebuilt and charges to be recalculated.

SCREEN 4 - EVENT INPATIENT INFORMATION
Screen 4 appears for inpatient bills only. This screen includes data concerning admission and discharge dates, principal diagnosis and procedures, prosthetics, and for accidents, the time the accident occurred. If the MCCR site parameter CAN CLERK ENTER NON-PTF CODES? is set to YES, diagnosis and procedure codes not found in the PTF record can be input into the billing record. Occurrence, condition, and value codes also appear on this screen.

Third Party Billing Menu
Enter/Edit Billing Information

Introduction, cont.

A print order can be specified for each procedure/diagnosis entered. If no print order is specified, the procedures/diagnoses will print in the order entered. The six procedures and nine diagnoses with the lowest print order will be printed in the boxes on the form and the remainder will print as additional procedures/diagnoses.

SCREEN 5 - EVENT OUTPATIENT
Screen 5 appears for outpatient bills only. This screen displays data concerning the diagnosis, coding method, and outpatient procedure codes. The coding method must be specified before outpatient procedure codes can be entered/edited. Diagnosis coding is possible on this screen. Information concerning prosthetics and prescription refills is located here. The RX original fill date for bills with a rate type of CHAMPVA will now be displayed (if within the bill's date range.) Occurrence, condition, and value codes also appear on this screen.

If the MCCR site parameter USE OP CPT SCREEN is set to YES, the Current Procedural Terminology Code Screen will appear when editing procedure codes. The screen will list CPT codes for the dates associated with the bill.

An associated diagnosis (diagnosis responsible for the procedure being performed) must be entered for each procedure for HCFA-1500s. You can enter from 1 to 4 associated diagnoses. The associated diagnosis must match one of the first four diagnoses entered.

Adding a BASC procedure or an OP VISIT DATE will cause the revenue codes to be rebuilt and charges recalculated for both UB-82/92 and HCFA-1500 form types. Only one visit date is allowed on a UB-82/92 that also has BASC procedures. This restriction does not apply to HCFA-1500s.

A print order can be specified for each procedure/diagnosis entered. If no print order is specified, the procedures/diagnoses will print in the order entered. The six procedures and nine diagnoses with the lowest print order will be printed in the boxes on the form and the remainder will print as additional procedures/diagnoses.

If the TRANSFER PROCEDURES TO SCHED? parameter is set to YES, any ambulatory surgery entered on the bill can be transferred to the Scheduling Visits file and stored under a 900 stop code. An associated clinic must be entered for all procedures that are to be transferred to the SCHEDULING VISITS file.

Third Party Billing Menu
Enter/Edit Billing Information

Introduction, cont.

SCREEN 6 & 7 - BILLING GENERAL INFORMATION
The Billing Screen appears differently for inpatient (Screen 6) and outpatient (Screen 7) episodes. Both screens include bill from and to dates, charges, bill type, time frame, covered and non-covered days, and assignment of benefits. If the billing period crosses fiscal or calendar years, two separate bills must be prepared (one for each fiscal/calendar year). Adding an OP VISIT DATE or entering the STATEMENT FROM and STATEMENT TO dates will cause the revenue codes to be rebuilt and charges to be recalculated for both UB-82/92 and HCFA-1500 forms.

Screen 6 also contains the discharge bedsection and length of stay (in days). The automatic length of stay calculation excludes the date of discharge. For interim first and interim continuous bills, each day is added to the length of stay so interim bills do not overlap. Screen 7 allows for input of outpatient visit dates, up to 30 visits per bill. Only one visit date is allowed on UB-82/92s that also have BASC procedures. This restriction does not apply to HCFA-1500s.

Revenue codes and rates are automatically calculated. You can add additional revenue codes. Each revenue code will be associated with a bedsection. To itemize a CHAMPVA outpatient bill, a CPT procedure code may be added to each revenue code on Screen 7.

When editing a sensitive record, (one which contains information pertaining to drugs, alcohol, sickle cell anemia, or other sensitive information), the user will be prompted for R.O.I. form. This field denotes whether or not release of information forms have been signed.

When entering an offset amount (amount to be subtracted from the total charges on the bill; i.e., copayment, deductible), entry of an offset description can also be entered.

When entering a third party bill (anything not billed to the patient), the ASSIGNMENT OF BENEFITS field will automatically be set to YES and cannot be edited.

Third Party Billing Menu
Enter/Edit Billing Information

Introduction, cont.

SCREEN 8 - BILLING SPECIFIC INFORMATION
For UB-92 forms, this screen contains the bill remark, treatment authorization code, admitting diagnosis, attending and other physicians, and those locators on the billing form which are unlabeled (locator 49 is uneditable). The UB-82 form excludes specific fields for the admitting diagnosis and the physicians; however, they can be entered into the unlabeled form locators. For HCFA-1500 forms, this screen contains the unable to work from and to dates, Block 31 entry/edit, and treatment authorization code.

Several site parameters and two security keys affect the prompts which appear at the end of this option. Please see the Data Supplement at the end of this option documentation for an explanation of how these site parameters and security keys affect the option.

A mail group can be specified (through the site parameters) so that every time a bill is disapproved during the authorization phase of the billing process, all members of this group are notified via electronic mail. If this group is not specified, only the billing supervisor, the initiator of the billing record, and the user who disapproved the bill will be recipients of the message. An example of this message can be found in the Data Supplement.

The UB-82, UB-92, and HCFA-1500 billing forms are the output which can be produced from this option. The data elements and design of these forms has been determined by the National Uniform Billing Committee and has been adapted to meet the specific needs of the Department of Veterans Affairs. They must be generated (printed) at 80 characters per line at 10 pitch. Copies of the billing forms are included in the Print Bill option documentation.

The UB-82, UB-92, and HCFA-1500 billing forms are the output which may be produced from this option. The data elements and design of these forms has been determined by the National Uniform Billing Committee and has been adapted to meet the specific needs of the Department of Veterans Affairs. They must be generated (printed) at 80 characters per line at 10 pitch. Copies of the billing forms are included in the Print Bill option documentation.

Third Party Billing Menu
Enter/Edit Billing Information

Example 1 - Inpatient Bill

```
Enter BILL NUMBER or PATIENT NAME:    JACKSON,SALLY          02-09-60     208442336
YES     SC VETERAN

                          *** WARNING ***
                     *** RESTRICTED RECORD ***
                *** ELIGIBILITY NOT VERIFIED ***

Patient Requires a Means Test
Primary Means Test Required from ''

  1   OCT 4,1996         K700020  REIM INS-Opt              ENTERED
  2   OCT 3,1996         K700019  REIM INS-Opt              ENTERED
  3   OCT 1,1996         K700016  REIM INS-Inpt             ENTERED
  4   OCT 1,1996         K700017  REIM INS-Opt              ENTERED
  5   OCT 1,1996         K700018  REIM INS-Opt              ENTERED

PRESS <RETURN> TO CONTINUE, OR
CHOOSE 1-5:  ^

DO YOU WANT TO ESTABLISH A NEW BILLING RECORD FOR ' JACKSON,SALLY '? No//       y  (Yes)
   BILLING LOCATION OF CARE: 1//    1  HOSPITAL (INCLUDES CLINIC) - INPT. OR OPT.
BILLING BILL CLASSIFICATION:    1  INPATIENT (MEDICARE PART A)
   BILLING TIMEFRAME OF BILL:    1  ADMIT THRU DISCHARGE CLAIM
   BILLING IS THIS A SENSITIVE RECORD?: NO//     NO  (NO)
   BILLING RATE TYPE:    reiMBURSABLE INS.       Who's Responsible: INSURER
    Select INPATIENT EVENT (ADMISSION) DATE:
        1   JAN 23,1996@16:18:06        2   AUG 22,1994@13:09:55
        3   AUG 16,1994@13:00           4   APR 2,1994@15:00
        5   MAR 31,1994@12:00           6   JAN 21,1994@19:42:24
        7   JAN 13,1994@22:22:30        8   NOV 15,1993@13:03:01
        9   MAR 3,1993@13:00            10   JUL 5,1990@10:38
    OR
    Select NON-VA INPATIENT EVENT (ADMISSION) DATE:
        11   DEC 17,1991                12   JUL 9,1994@09:00
        13   JUL 25,1994                14   AUG 14,1994

    CHOOSE 1-14 or Enter DATE:     1
    PTF record indicates 0 of 1 movements are for Service Connected Care.

  Insurance Co.     Subscriber ID     Group       Holder  Effectve Expires  Only
  ================================================================================
  NEW HEALTH        9999              Ind. Plan   SPOUSE  08/04/93 05/31/94
  BC/BS OF ALBANY   208442336                     SELF    07/01/94
  ABC               SI333             HJKJ        SELF    11/12/94
```

Third Party Billing Menu
Enter/Edit Billing Information

Example 1 - Inpatient Bill, cont.

```
JACKSON,SALLY   208-44-2336   BILL#: K700059 - Inpatient            SCREEN <6>
================================================================================
                          BILLING - GENERAL INFORMATION
[1] Bill Type   : 111                Timeframe: ADMIT THRU DISCHARGE
    Covered Days: UNSPECIFIED Non-Covered Days: UNSPECIFIED
    Division    :
[2] Sensitive?  : NO                Assignment: YES
[3] Bill From   : JAN 23, 1996         Bill To: SEP 30, 1996
[4] Bedsection  : UNSPECIFIED
    LOS         : 251
[5] Rev. Code   : 101-ALL INCL R&B              $150,098.00  GENERAL MEDICAL
    Rev. Code   : 240-ALL INCL ANCIL             $63,252.00  GENERAL MEDICAL
    Rev. Code   : 960-PRO FEE                    $29,116.00  GENERAL MEDICAL
    OFFSET      :       $0.00   [NO OFFSET RECORDED]
    BILL TOTAL  : $242,466.00
    FY 1        : 96                    Charges: $242,466.00
[6] Rate Sched  : (re-calculate charges)


<RET> to CONTINUE, 1-6 to EDIT, '^N' for screen N, or '^' to QUIT:      1
TIMEFRAME OF BILL: ADMIT THRU DISCHARGE CLAIM//     <RET>
COVERED DAYS:  8
NON-COVERED DAYS:  1
DEFAULT DIVISION:  <RET>

JACKSON,SALLY   208-44-2336   BILL#: K700059 - Inpatient            SCREEN <6>
================================================================================
                          BILLING - GENERAL INFORMATION
[1] Bill Type   : 111                Timeframe: ADMIT THRU DISCHARGE
    Covered Days: 8           Non-Covered Days: 1
    Division    :
[2] Sensitive?  : NO                Assignment: YES
[3] Bill From   : JAN 23, 1996         Bill To: SEP 30, 1996
[4] Bedsection  : UNSPECIFIED
    LOS         : 251
[5] Rev. Code   : 101-ALL INCL R&B              $150,098.00  GENERAL MEDICAL
    Rev. Code   : 240-ALL INCL ANCIL             $63,252.00  GENERAL MEDICAL
    Rev. Code   : 960-PRO FEE                    $29,116.00  GENERAL MEDICAL
    OFFSET      :       $0.00   [NO OFFSET RECORDED]
    BILL TOTAL  : $242,466.00
    FY 1        : 96                    Charges: $242,466.00
[6] Rate Sched  : (re-calculate charges)


<RET> to CONTINUE, 1-6 to EDIT, '^N' for screen N, or '^' to QUIT:      <RET>
```

Third Party Billing Menu
Enter/Edit Billing Information

Example 2 - Outpatient Bill

```
Enter BILL NUMBER or PATIENT NAME:       K700018       JACKSON,SALLY     10-01-96
    Outpatient     REIMBURSABLE INS.     ENTERED/NOT REVIEWED
                *** ELIGIBILITY NOT VERIFIED ***

Patient Requires a Means Test
Primary Means Test Required from ''


JACKSON,SALLY   208-44-2336   BILL#: K700018 - Outpatient           SCREEN <1>
================================================================================
                            DEMOGRAPHIC INFORMATION
[1] DOB    : FEB 9,1960
[2] Alias  : NO ALIAS ON FILE
[3] Sex    : FEMALE                    Marital: NEVER MARRIED
[4] Veteran: YES                   Eligibility: SC, LESS THAN 50%

[5] Address: 415 SUMMER STREET       Temporary: NO TEMPORARY ADDRESS
SUMMERVILLE, PA 15221

[6] Pt Short
    Address: 415 SUMMER STREET,APT #10,SUMMERVILLE,PA 15221

[7] SC Care: YES  (Enter '7' to list disabilities)



<RET> to CONTINUE, 1-7 to EDIT, '^N' for screen N, or '^' to QUIT:      <RET>


JACKSON,SALLY   208-44-2336   BILL#: K700018 - Outpatient           SCREEN <2>
================================================================================
                            EMPLOYMENT INFORMATION
[1] Employer: MACY'S           <2> Spouse's: UNSPECIFIED
              STREET ADDRESS UNKNOWN
              CITY/STATE UNKNOWN
       Phone: UNSPECIFIED
  Occupation: SALES PERSON
      Status: RETIRED



<RET> to CONTINUE, 1-2 to EDIT, '^N' for screen N, or '^' to QUIT:      <RET>
```

Third Party Billing Menu
Enter/Edit Billing Information

Example 2 - Outpatient Bill, cont.

```
JACKSON,SALLY    208-44-2336   BILL#: K700018 - Outpatient           SCREEN <5>
================================================================================
                          EVENT - OUTPATIENT INFORMATION
<1> Event Date : OCT 01, 1996
[2] Prin. Diag.: UNSPECIFIED [NOT REQUIRED]
[3] OP Visits  : OCT 1,1996, OCT 2,1996, OCT 4,1996,
[4] Cod. Method: UNSPECIFIED [NOT REQUIRED]
[5] Rx. Refills: UNSPECIFIED [NOT REQUIRED]
[6] Pros. Items: UNSPECIFIED [NOT REQUIRED]
[7] Occ. Code  : UNSPECIFIED [NOT REQUIRED]
[8] Cond. Code : UNSPECIFIED [NOT REQUIRED]
[9] Value Code : UNSPECIFIED [NOT REQUIRED]



<RET> to CONTINUE, 1-9 to EDIT, '^N' for screen N, or '^' to QUIT:      <RET>

JACKSON,SALLY    208-44-2336   BILL#: K700018 - Outpatient           SCREEN <7>
================================================================================
                           BILLING - GENERAL INFORMATION
[1] Bill Type   : 131               Timeframe: ADMIT THRU DISCHARGE
    Covered Days: UNSPECIFIED          Division:
    Non-Cov Days: UNSPECIFIED        Disch Stat:
[2] Sensitive?  : NO               Assignment: YES
[3] Bill From   : OCT 01, 1996        Bill To: OCT 04, 1996
[4] OP Visits   : OCT 1,1996, OCT 2,1996, OCT 4,1996,
[5] Rev. Code   : 500-OUTPATIENT SVS               $582.00  OUTPATIENT VISIT
    OFFSET      :       $0.00   [NO OFFSET RECORDED]
    BILL TOTAL  :     $582.00
    FY 1        : 97                   Charges:     $582.00
[6] Rate Sched  : (re-calculate charges)


<RET> to CONTINUE, 1-5 to EDIT, '^N' for screen N, or '^' to QUIT:      <RET>

JACKSON,SALLY   208-44-2336   BILL#: K700018 - Outpatient           SCREEN <8>
================================================================================
                           BILLING - SPECIFIC INFORMATION
[1] Bill Remark     : UNSPECIFIED [NOT REQUIRED]
    Tx Auth. Code   : UNSPECIFIED [NOT REQUIRED]
    Admitting Dx    : UNSPECIFIED [NOT REQUIRED]
[2] Attending Phy.  : UNSPECIFIED [NOT REQUIRED]
    Other Physician : UNSPECIFIED [NOT REQUIRED]
[3] Form Locator 2  : UNSPECIFIED [NOT REQUIRED]
    Form Locator 11 : UNSPECIFIED [NOT REQUIRED]
[4] Form Locator 31 : UNSPECIFIED [NOT REQUIRED]
    Form Locator 37 : UNSPECIFIED [NOT REQUIRED]
[5] Form Locator 56 : UNSPECIFIED [NOT REQUIRED]
    Form Locator 57 : UNSPECIFIED [NOT REQUIRED]
    Form Locator 78 : UNSPECIFIED [NOT REQUIRED]


<RET> to CONTINUE, 1-5 to EDIT, '^N' for screen N, or '^' to QUIT:      <RET>
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Third Party Billing Menu
Enter/Edit Billing Information

DATA SUPPLEMENT
This section is provided to give further clarification to the following elements which appear in the Enter/Edit Billing Information option.

Fields	Explanation of select fields (data items) found in this option.
Parameters and Security Keys	Explanation of select parameters and security keys which affect the functioning of this option.
Mail Messages	Example of electronic mail messages generated by this option.
Billing Mailing Address	Explanation of how the billing mailing address is determined.

FIELDS

SCREEN	FIELD NAME	DESCRIPTION
1	Patient Short Mailing Address	Abbreviated patient mailing address (if necessary). Address cannot exceed 47 characters for billing form.
1	SC at Time of Care	Was this patient service connected for any condition at the time the care in the bill was rendered. This field is used to correctly assign Accounts Receivable AMIS segments to this bill if it is a Reimbursable Insurance bill. The default for this field is the current value in the SC PATIENT field of the PATIENT file. If this field is left blank, the default value will be used to determine the AMIS segment.
3	Institution Name	When payer is "other", name of institution responsible for payment of bill (i.e., other VAMC, federal agency, private hospital).

Third Party Billing Menu
Delete Auto Biller Results

EXAMPLE
The following example shows what might appear on your screen while using this option. User responses appear in boldface type.

```
Select Third Party Billing Menu Option:    Delete Auto Biller Results
End Date for Delete: Dec 24, 1993//   <RET>

  (DEC 24, 1993).............................
.........
```

Third Party Billing Menu
Print Bill

Updates to HCFA-1500 form -
It is now possible to charge the same CPT different dollar amounts on the same bill.

If the same CPT has been added to the bill more than once and one or neither of them has a print order, they will be combined as a single line item on the bill.

Block 28 now contains the total charges reported in block 24. Block 29 contains the total of the primary, secondary, and tertiary payments. Block 30 contains the difference between block 28 and block 29.

Updates to UB-92 form -
If a charge is printed for a procedure with a modifier, the modifier will be printed with the CPT in Block 44.

Form Locator 48 now contains the contents of the non-covered charges field for a revenue code.

The bill number on both the HCFA-1500 (Block 26) and the UB-92 (Form Locator 3) are now the AR bill number, including the station number.

Introduction

The Print Bill option is used to print third party bills on the appropriate form (UB-82/92 or HCFA-1500) after all required information has been input and the billing record has been authorized. You may also reprint a previously printed bill.

A final review of the information in the billing record may be performed through this option. The data is arranged so that it may be viewed through various screens. The patient's name, social security number, bill number, the bill classification (Inpatient or Outpatient), and the screen number appear at the top of every screen. A <?> entered at the prompt which appears at the bottom of each screen will provide you with a HELP SCREEN for that particular screen. The HELP SCREEN lists the name and number of each available screen for the bill you are working on and the data groups for that particular screen.

Third Party Billing Menu
Print Bill

Introduction, cont.

No editing of the data is allowed in this option. Data can be edited through the Enter/Edit Billing Information option, if necessary.

The UB-82, UB-92, and HCFA-1500 billing forms are the output which may be produced from this option. The data elements and design of these forms has been determined by the National Uniform Billing Committee and has been adapted to meet the specific needs of the Department of Veterans Affairs. They must be generated (printed) at 80 characters per line at 10 pitch. Copies of the billing forms are included in the example portion of this option documentation.

Example

```
Enter BILL NUMBER or PATIENT NAME:    BAILEY,GEORGE B   12-09-50   123456765
SC VETERAN

  1   JUN 1,1997      L10342   REIM INS-Opt     ENTERED/NOT REVIEWED

CHOOSE 1:   1

Entered        : JUN  2, 1997 by HOUSER,DOUGLAS
Authorized     : JUN 11, 1997 by CASEY,BENJAMIN

WANT TO REVIEW SCREENS? NO//    <RET>   (NO)

WANT TO PRINT BILL AT THIS TIME? NO//    Y    (YES)

Output Device: A200//    <RET>
DO YOU WANT YOUR OUTPUT QUEUED? NO//    Y   (YES)

Requested Start Time: NOW//    <RET>   (JUN 12,1997@13:49)
```

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Third Party Joint Inquiry

EXAMPLE, cont.

```
Patient Eligibility          May 20, 1996 07:45:44          Page:    1 of    1
N10273   JONES,ANDREW  A9281             DOB: 07/07/50   Subsc ID:

             Means Test: CATEGORY A                        Insured: Yes
          Date of Test: 08/24/94                     A/O Exposure:
  Co-pay Exemption Test:                            Rad. Exposure:
          Date of Test:

     Primary Elig. Code: NSC
    Other Elig. Code(s): EMPLOYEE
                         AID & ATTENDANCE
      Service Connected: No
     Rated Disabilities: BONE DISEASE (0%-NSC)
                         DEGENERATIVE ARTHRITIS (40%-NSC)


          Enter ?? for more actions
BC  Bill Charges          AR  Account Profile       VI  Insurance Company
DX  Bill Diagnosis        CM  Comment History       VP  Policy
PR  Bill Procedures       IR  Insurance Reviews     AB  Annual Benefits
CI  Go to Claim Screen    HS  Health Summary        EX  Exit Action
                          AL  Go to Active List
Select Action: Quit//
```

CHAMPUS Billing Menu
Delete Reject Entry

New Option

Introduction

This option allows you to delete individual entries from the CHAMPUS PHARMACY REJECTS (#351.52) file. Entries are automatically deleted from this file when a rejected transmission is re-submitted and subsequently approved. However, there will be instances when rejected transmissions will not be re-submitted. Therefore, this option may be used to purge unwanted reject transactions from the file.

Example

```
Enter the RX# of the rejected transmission:    100136

Prescription: 100136
     Patient: MINARDI,JOHN

The original fill for this prescription has been rejected.
Is it okay to delete this reject entry?    YES
The reject entry has been deleted.
```

CHAMPUS Billing Menu
Reject Report

New Option

Introduction

The Reject Report allows you to view all of the entries in the CHAMPUS PHARMACY REJECTS (#351.52) file and determine the reason(s) for the rejected entries. Rejected entries for transactions which will not be re-submitted and continue to be displayed on this report may be deleted using the Delete Reject Entry option.

Example

```
================================================================================
Date: 05/30/97            IPS Unresolved Reject Report                Page:  1
================================================================================

RX# 100136, filled on 09/10/96 (MINARDI,JOHN 434534531) rejected because:
    Invalid NDC Number
    Missing/Invalid Insurance data
    NDC not in local AWP file
    Call Failed

RX# 100114, filled on 02/03/94 (SMITH,MARY-JO E 524051064P) rejected because:
    Modem is not Responding
    Bad/Invalid baud Rate Setting
    Call Interrupted by User
    Bad/Invalid Data bits Setting
```

CHAMPUS Billing Menu
Resubmit a Claim

New Option

Introduction

This option is used to re-submit a transaction which was originally rejected by the FI (Fiscal Intermediary - the company with which a Tricare patient holds their Tricare insurance coverage). The user is allowed to select a prescription which has not been submitted for billing, or was submitted and then rejected. The prescription is then placed in the queue to be processed by the IB background filer, and it is processed in the same manner as prescriptions which are queued by the foreground processor. If the prescription was previously submitted and rejected, the reject entry in file #351.52 will automatically be deleted if the prescription is authorized for billing.

Example

```
Enter the RX# you wish to resubmit:   100136

Prescription: 100136
     Patient: MINARDI,JOHN

The original fill for this prescription can be billed.
Is it okay to bill this prescription?   YES
Outpatient Pharmacy software - Version 6.0

Division:  ALBANY ISC

          You are logged on under the ALBANY ISC division.

Select LABEL PRINTER:  A400-10/6/UP  HP IIIsi RIGHT MARGIN: 80//   <RET>

OK TO ASSUME LABEL ALIGNMENT IS CORRECT ? YES//   <RET>
The prescription has been submitted for billing.
```

CHAMPUS Billing Menu
Reverse a Claim

New Option

Introduction

This option may be used to reverse or cancel a claim for a prescription that was submitted in error. The user is allowed to select a prescription which was previously billed. The prescription is then placed in the queue to be processed by the IB background filer. The filer creates a cancellation-type transaction message which is transmitted to the RNA package. When the receipt confirmation has been received by VISTA from the Fiscal Intermediary (FI), through RNA, another job is queued which cancels the patient copayment charge and the claim for the FI.

Example

```
Enter the RX# you wish to reverse:   100136

Prescription: 100136
     Patient: MINARDI,JOHN
 The claim for the original fill for this prescription was rejected.

Enter the RX# you wish to reverse:   100114

Prescription: 100114
     Patient: SMITH,MARY-JO E

More than one fill for rx# 100114 may be canceled.

     Select one of the following:

          0         Original Fill (filled 01/04/94)
          1         Refill #1 (filled 02/03/94)

Select one of the fills by number:   1  Refill #1 (filled 02/03/94)
Is it okay to cancel this prescription?   YES
The claim reversal has been submitted.
```

CHAMPUS Billing Menu
Transmission Report

New Option

Introduction

The Transmission report allows you to view a list of pharmacy transmissions for prescriptions which were filled during a specified date range.

Example

```
==========================================================================
Date: 05/30/97          IPS Prescription Status Report               Page: 1
                      JAN 1,1996 through MAY 30,1997
RX#            Fill Date   Patient Name                       Patient SSN
NDC            AWP       Copay     Ing Cost  Fee Paid  Total PD
               Auth. #                Message
Reject Failure Codes
==========================================================================


100136         09/10/96    MINARDI,INS                        434534531
  Drug Name: PRESAMINE 50MG TABS
     Status: Rejected
    Invalid NDC Number
    Missing/Invalid Insurance data
    NDC not in local AWP file
    Call Failed
```

Option Overview

PATIENT INSURANCE INFO VIEW/EDIT - Used to look at a patient's insurance information and edit that data, if necessary.

VIEW PATIENT INSURANCE - Used to look at a patient's insurance information.

INSURANCE COMPANY ENTRY/EDIT - Used to enter new insurance companies into the INSURANCE COMPANY file and edit data on existing companies.

VIEW INSURANCE COMPANY - Used to look at data related to a selected insurance company.

LIST INACTIVE INS. CO. COVERING PATIENTS - Provides a listing of inactive insurance companies that are listed in the system as providing coverage.

LIST PLANS BY INSURANCE COMPANY - Produces a list of insurance plans offered by one or more insurance companies. May also be used to provide a list of subscribers for one or more insurance plans at one or more insurance companies.

LIST NEW NOT VERIFIED POLICIES - Produces a list, by patient, of new insurance entries that have not been verified.

Patient Insurance Info View/Edit

The Type of Policy field has been changed to display the Type of Plan rather than the Type of Plan's Major Category.

Introduction

The Patient Insurance Info View/Edit option is used to look ata patient's insurance information and edit that data, if necessary. The system groups information that is specific to the insurance company, specific to the patient, specific to the group plan, specific to the annual benefits available, and the annual benefits already used. Inactive policies will be listed as long as the patient has not been repointed from that inactive policy to an active policy.

About the Screens...

In the top left corner of each screen is the screen title. On some screens, the following line is a description of the information displayed. A plus sign (+) at the bottom of the screen indicates there are additional screens. Left or right arrows (<<< >>>) may be displayed to indicate there is additional information to the left or right of the screen. Available actions are displayed below the screen. <??> entered at any "Select Action" prompt displays all available actions for that screen.

You may QUIT from any screen which will bring you back one level or screen. EXIT is also available on most screens. When EXIT is entered, you are asked if you wish to "Exit option entirely?". A YES response returns you to the menu. A NO response has the same result as the QUIT action. For more information on the use of the List Manager utility, please refer to the appendix at the end of this manual.

Following is a listing of the screens found in this option and a brief description of the actions they allow. Actions shown in *italics* access other screens. Once an action has been selected, <??> may be entered at most of the prompts that appear for lists of acceptable responses or instruction on how to respond.

Patient Insurance Management Screen

Once a patient is selected, this screen is displayed listing all the patient's insurance policies. Information provided for each policy may include type of policy, group name, holder, effective date, and expiration date.

Patient Insurance Info View/Edit

Introduction, cont.

Actions

AP Add Policy - Allows you to add an insurance policy for the selected patient.

VP Policy Edit/View (accesses Patient Policy Information screen) - Allows you to view and edit extensive insurance policy data.

DP Delete Policy - Allows you to delete an insurance policy for the selected patient. IB INSURANCE SUPERVISOR security key is required.

AB Annual Benefits - (accesses Annual Benefits Editor screen) - Used to enter annual benefits data for the selected policy.

EA Fast Edit All - A quick way to enter portions of the patient insurance information.

BU Benefits Used (accesses the Benefits Used By Date Editor screen) - Used to enter policy benefits already used.

VC Verify Coverage - Allows the user to enter into the system verification that the insurance coverage exists and the information is correct.

RI Personal Riders - Displays current riders and allows addition of new riders.

CP Change Patient - Allows you to change to another patient without returning to the beginning of the option.

WP Worksheet Print - Used to print the standard worksheet showing the data for the benefit year within the past 12 months. If no benefit year on file, will print the standard form without the data. Must be printed at 132 column margin width.

PC Print Insurance Cov. - Similar to worksheet. Used when bulk of information is already in the computer. Will show two most recent benefit years. If no benefit years on file, will offer WP action (see above).

Patient Insurance Info View/Edit

Introduction, cont.

Patient Policy Information Screen
This screen is displayed listing expanded policy information for the selected company. Categories include utilization review data, subscriber data, subscriber's employer information, effective dates, plan coverage limitations, last contact, and comments on the patient policy or insurance group plan. The sections on user informa-tion and insurance company information are not editable.

Actions

PI Change Plan Info - Allows entry/edit of group plan information.

UI UR Info - Allows entry/edit of utilization review information.

ED Effective Dates - Allows you to edit the effective date and expiration date of the insurance policy.

SU Subscriber Update - Allows you to edit the subscriber (person who holds the insurance coverage) information.

IP Inactive Plan - Allows you to inactivate an insurance plan, or move subscribers from multiple insurance plans into one master plan.

IC Insur. Contact Inf. - Allows you to add/edit the last insurance contact.

EM Employer Info - Allows you to edit the subscriber's employer information.

AC Add Comment - Allows the user to add a comment regarding the patient's policy or the insurance group plan.

EA Fast Edit All - A quick way to enter portions of the patient insurance information.

CP Change Policy Plan - Allows you to change the plan to which a veteran is subscribing.

VC Verify Coverage - Allows the user to enter into the system verification that the insurance coverage exists and the information is correct.

Patient Insurance Info View/Edit

Introduction, cont.

AB Annual Benefits (accesses Annual Benefits Editor screen) - Used to enter annual benefits data for the selected policy.

CV Add/Edit Coverage - Allows you to add or edit coverage limitations for a specific plan.

BU Benefits Used - (accesses the Benefits Used By Date Editor screen) - Used to enter policy benefits already used.

Annual Benefits Editor Screen

Once the benefit year is selected, this screen is displayed listing all the benefits for the selected insurance policy and benefit year. Benefit categories may include inpatient benefits, outpatient benefits, mental health, home health care, hospice, rehabilitation, and IV management.

Actions

PI Policy Information - Allows entry/edit of maximum out of pocket and ambulance coverage.

IP Inpatient - Allows entry/edit of inpatient benefits data.

OP Outpatient - Allows entry/edit of outpatient benefits data.

MH Mental Health - Allows entry/edit of mental health inpatient and outpatient benefits data.

HH Home Health - Allows entry/edit of home health care benefits data.

HS Hospice - Allows entry/edit of hospice benefits data.

RH Rehab - Allows entry/edit of rehabilitation benefits data.

IV IV Mgmt. - Allows entry/edit of intravenous management benefits data.

Patient Insurance Info View/Edit

Introduction, cont.
EA Edit All - Lists editable fields line by line for quick data entry.

CY Change Year - Allows you to change to another benefit year.

Benefits Used By Date Editor Screen
Once the benefit year is selected, this screen is displayed
listing all the benefits used for the selected insurance policy and benefit year.
Benefit categories may include inpatient and outpatient deductibles.

PI Policy Info - Allows entry/edit of policy information such as deductible met and pre-existing conditions.

OD Opt Deduct - Allows entry/edit of the outpatient deductible insurance information.

ID Inpt Deduct - Allows entry/edit of the inpatient deductible insurance information.

AC Add Comment - Allows the user to add a comment regarding claims filed.

EA Edit All - A quick way to enter portions of the patient insurance information.

CY Change Year - Allows you to change to another benefit year.

Patient Insurance Info View/Edit

Example

```
Select PATIENT NAME:  DUMONT,ROLAND          11-28-31     020248845     YES
SC VETERAN  ..


Patient Insurance Management  Nov 22, 1993 13:51:09          Page:  1 of    1
Insurance Management for Patient: DUMONT,ROLAND D8845

    Insurance Co.     Type of Policy   Group        Holder   Effect.    Expires
1   RIGHA                              1546         UNKNOWN
2   PRUDENTIAL        SURGICAL EXPENS  123          SELF     04/01/93

          Enter ?? for more actions                                        >>>
AP  Add Policy            EA  Fast Edit All         CP  Change Patient
VP  Policy Edit/View      BU  Benefits Used         WP  Worksheet Print
DP  Delete Policy         VC  Verify Coverage       PC  Print Insurance Cov.
AB  Annual Benefits       RI  Personal Riders       EX  Exit
Select Item(s): Quit//   VP=2   Policy Edit/View  ..........




Patient Policy Information    Nov 22, 1993 13:51:39       Page:    1 of    3
Expanded Policy Information for: DUMONT,ROLAND     013-92-8845
PRUDENTIAL Insurance Company                       ** Plan Currently Active **

  Plan Information                          Insurance Company
    Is Group Plan: YES                         Company: PRUDENTIAL
       Group Name: PACKERS                      Street: 123 MAIN STREET
     Group Number: 123                       City/State: YORKVILLE, NY 33343
     Type of Plan: SURGICAL EXPENSE INSURANCE


  Utilization Review Info                     Effective Dates
          Require UR: YES                     Effective Date: 04/01/93
    Require Pre-Cert: YES                    Expiration Date:
    Exclude Pre-Cond: NO
 Benefits Assignable: YES

+         Enter ?? for more actions
PI  Change Plan Info      IC  Insur. Contact Inf.   CP  Change Policy Plan
UI  UR Info               EM  Employer Info         VC  Verify Coverage
ED  Effective Dates       CV  Add/Edit Coverage     AB  Annual Benefits
SU  Subscriber Update     AC  Add Comment           BU  Benefits Used
IP  Inactivate Plan       EA  Fast Edit All         EX  Exit
Select Item(s): Quit//   AB=2   Annual Benefits
```

Patient Insurance Info View/Edit

Example, cont.

```
Current benefit years on file:
    1.  12/01/93
BENEFIT YEAR BEGINNING ON: 12/01/93//   <RET>   DEC  1, 1993    ............
```

```
Annual Benefits Editor        Nov 22, 1993 14:17:36        Page:    1 of    4
Annual Benefits for: PRUDENTIAL Ins. Co
             Policy: 123                              Ben Yr: DEC  1, 1992
-------------------------------------------------------------------------------
                          Policy Information
                     Max. Out of Pocket: $  300
                  Ambulance Coverage (%):    80%



                                  Inpatient
      Annual Deductible: $  200         Drug/Alcohol Lifet. Max: $ 8888
  Per Admis. Deductible: $   40         Drug/Alcohol Annual Max: $  888
     Inpt. Lifetime Max: $ 9999                Nursing Home (%):    80%
       Inpt. Annual Max: $  999         Other Inpt. Charges (%):    80%
       Room & Board (%):    80%

+         Enter ?? for more actions                                        >>>
PI  Policy Info           HH  Home Health           EA  Edit All
IP  Inpatient             HS  Hospice               CY  Change Year
OP  Outpatient            RH  Rehab                 EX  Exit
MH  Mental Health         IV  IV Mgmt.
Select Action: Next Screen//   OP   Outpatient
```

```
ANNUAL DEDUCTIBLE (OPT): 200//   225
PER VISIT DEDUCTIBLE: 25//   <RET>
OUTPATIENT LIFETIME MAXIMUM: 9999//   <RET>
OUTPATIENT ANNUAL MAXIMUM: 666//   <RET>
OUTPATIENT VISIT (%): 80//   <RET>
OUTPATIENT VISITS PER YEAR: 32//   <RET>
OUTPATIENT SURGERY (%): 80//   <RET>
EMERGENCY OUTPATIENT (%): 80//   <RET>
PRESCRIPTION (%): 40//   <RET>
ADULT DAY HEALTH CARE:   0  NO
DENTAL COVERAGE TYPE: PER VISIT AMOUNT//   <RET>
DENTAL COVERAGE $ OR %: 80//   <RET>.............
```

Patient Insurance Info View/Edit

Example, cont.

```
Annual Benefits Editor        Nov 22, 1993 14:18:25          Page:   2 of    4
Annual Benefits for: PRUDENTIAL Ins. Co
            Policy: 123                              Ben Yr: DEC  1, 1992
+
                                    Outpatient
      Annual Deductible: $  225                    Surgery (%):    80%
   Per Visit Deductible: $   25                  Emergency (%):    80%
           Lifetime Max: $ 9999               Prescription (%):    40%
             Annual Max: $  666         Adult Day Health Care?:    80
              Visit (%):    80%               Dental Cov. Type: PER VISIT AMOUNT
    Max Visits Per Year:    32                    Dental Cov.:   80

    Mental Health Inpatient                 Mental Health Outpatient
 MH Inpt. Max Days/Year:    75              MH Opt. Max Days/Year:    30
  MH Lifetime Inpt. Max: $  400               MH Lifetime Opt. Max: $  300
    MH Annual Inpt. Max: $  500                 MH Annual Opt. Max: $  400
Mental Health Inpt. (%):    80%            Mental Health Opt. (%):    80%

+         Enter ?? for more actions                                          >>>
PI  Policy Info           HH  Home Health           EA  Edit All
IP  Inpatient             HS  Hospice               CY  Change Year
OP  Outpatient            RH  Rehab                 EX  Exit
MH  Mental Health         IV  IV Mgmt.
Select Action: Next Screen//
```

View Patient Insurance

INTRODUCTION

The View Patient Insurance option is used to look at a patient's insurance information. The system groups information that is specific to the insurance company, specific to the patient, specific to the group plan, specific to the annual benefits available, and the annual benefits already used. Editing of the data is not allowed through this option.

About the Screens...

In the top left corner of each screen is the screen title. On some screens, the following line is a description of the information displayed. A plus sign (+) at the bottom of the screen indicates there are additional screens. Left or right arrows (<<< >>>) may be displayed to indicate there is additional information to the left or right of the screen. Available actions are displayed below the screen. <??> entered at any "Select Action" prompt displays all available actions for that screen.

You may QUIT from any screen which will bring you back one level or screen. EXIT is also available on most screens. When EXIT is entered, you are asked if you wish to "Exit option entirely?". A YES response returns you to the menu. A NO response has the same result as the QUIT action. For more information on the use of the List Manager utility, please refer to the appendix at the end of this manual.

Following is a listing of the screens found in this option and a brief description of the actions they allow. Actions shown in *italics* access other screens.

Patient Insurance Management Screen

Once a patient is selected, this screen is displayed listing all the patient's insurance policies. Information provided for each policy may include type of policy, group name or individual, holder, effective date, and expiration date.

VP View Policy Info (accesses Patient Policy Information screen) - Allows you to view extensive insurance policy data.

View Patient Insurance

Example, cont.

```
Patient Policy Information    Nov 22, 1993 15:27:55        Page:   2 of    3
Expanded Policy Information for: DUMONT,ROLAND
PRUDENTIAL Insurance Company
+
  Subscriber Information                Subscriber's Employer Information
  Whose Insurance: VETERAN           Claims to Employer: Yes, Send to Employer
  Subscriber Name: DUMONT,ROLAND                 Company: CANAL PAPER
     Relationship: PATIENT                        Street: 1865 STATE ST
 Insurance Number: 5948333                  City/State: SCHENECTADY, NY 12309
 Coord.  Benefits: PRIMARY                         Phone: 371-5233

  Plan Coverage Limitations
   Coverage            Effective Date   Covered?       Limit Comments
   --------            --------------   --------       --------------
   INPATIENT                            BY DEFAULT
   OUTPATIENT                           BY DEFAULT
   PHARMACY                             BY DEFAULT

+         Enter ?? for more actions
EX  Exit
Select Action:Next Screen//   <RET>
```

```
Patient Policy Information    Nov 22, 1993 15:30:06        Page:   3 of    3
Expanded Policy Information for: DUMONT,ROLAND
PRUDENTIAL Insurance Company
+
  User Information                       Insurance Contact (last)
       Entered By: REYNOLDS,NANCY        Person Contacted: SMITH,DON
       Entered On: 11/16/93             Method of Contact: VOICE MAIL
 Last Verified By: SIMMONS,ALAN           Contact's Phone:
 Last Verified On: 01/18/94                  Contact Date: JAN 05, 1994
  Last Updated By: SIMMONS,ALAN
  Last Updated On: 01/18/94

  Comment -- Patient Policy
 Policy has no expiration date.

  Comment -- Group Plan
   Dental coverage now provided.

          Enter ?? for more actions
EX  Exit
Select Action:Quit//
```

Insurance Company Entry/Edit

Now displays NO for ALLOW MULTIPLE BEDSECTIONS only if the field has been answered NO. Previously, NO was assumed if there was no answer in the field.

The Billing Parameters action of this option has been modified so that the user may enter the BIN number for an insurance carrier. This number ID is also displayed in the Insurance Company Editor screen. The BIN number must be entered for the company which is the Tricare FI (Fiscal Intermediary: the company with which the Tricare patient holds their Tricare insurance coverage). The BIN number is passed to the RNA package and transmitted to the electronic switch company, where it is used to determine the address for forwarding to the FI. If the BIN number is not entered, pharmacy claims will not be passed to the RNA system for submission to the FI.

Only national, print-type forms may be selected at the FORM TYPE field. A locally defined form name cannot be selected. The FORM TYPE field is used to determine the basic bill format, not the specific form that will print for the insurance company.

Introduction

The Insurance Company Entry/Edit option is used to enter new insurance companies into the INSURANCE COMPANY file and edit data on existing companies. An insurance company must be in the INSURANCE COMPANY file before it can be entered into a patient's record.

When entering new insurance companies, you will be prompted for the company street address, city, and whether or not the company will reimburse for treatment.

Following is a listing of the actions found on the screen in this option and a brief description of each. Once an action has been selected, <??> may be entered at most of the prompts that appear for lists of acceptable responses or instruction on how to respond.

Insurance Company Editor Screen

Once the insurance company is selected, this screen is displayed listing the following groups of information for that company: billing parameters, main mailing address, inpatient claims office data, outpatient claims office data, prescription claims office data, appeals office data, inquiry office data, remarks, and synonyms.

Insurance Company Entry/Edit

Introduction, cont.

BP Billing Parameters - Allows you to add/edit the billing parameters for the selected insurance company.

MM Main Mailing Address - Allows you to add/edit the company's main mailing address. The address entered here will automatically be entered for the other office addresses.

IC Inpt Claims Office - Allows you to add/edit the company's inpatient claims office name, address, phone and fax numbers.

OC Opt Claims Office - Allows you to add/edit the company's outpatient claims office name, address, phone and fax numbers.

PC Prescr Claims Of - Allows you to add/edit the company's prescription claims office name, address, phone and fax numbers.

AO Appeals Office - Allows you to add/edit the company's appeals office name, address, phone and fax numbers.

IO Inquiry Office - Allows you to add/edit the company's inquiry office name, address, phone and fax numbers.

RE Remarks - Allows the user to enter comments concerning the selected insurance company.

SY Synonyms - Allows you to add/edit any synonyms for the selected company.

EA Edit All - Lists editable fields line by line for quick data entry.

AI (In)Activate Company - Allows you to activate/inactivate the selected insurance company. This may be used to inactivate duplicate companies in the system. When an insurance company is no longer valid, it is important to inactivate the company rather than delete it from the system. The IB INSURANCE SUPERVISOR security key is required. Once a company has been inactivated, it may not be selected when entering billing information.

You may also obtain a report of patients insured by a given company through this action.

Insurance Company Entry/Edit

Introduction, cont.

CC Change Insurance Co. - Allows you to change to another company without returning to the beginning of the option.

DC Delete Company - Allows you to delete an entry from the INSURANCE COMPANY (#36) file. If claims have been submitted to the company, another company must be selected in which to point all claims and receivables information.

PL Plans (accesses Insurance Plan List screen) - Allows you to display and change plan attributes associated with the insurance company.

Insurance Plan List Screen

This screen lists all plans (active and inactive, group and individual) for the selected insurance company.

Actions

VP View/Edit Plan (accessesView/Edit Plan screen)- Allows you to display /change plan detailed information.

IP Inactive Plan - Allows you to inactivate an insurance plan, or move subscribers from multiple insurance plans into one master plan.

AB Annual Benefits - (accesses Annual Benefits Editor screen) - Used to enter annual benefits data for the selected policy.

Annual Benefits Editor Screen

Once the benefit year is selected, this screen is displayed listing all the benefits for the selected insurance policy and benefit year. Benefit categories may include inpatient benefits, outpatient benefits, mental health, home health care, hospice, rehabilitation, and IV management.

Actions

PI Policy Information - Allows entry/edit of maximum out of pocket and ambulance coverage.

Insurance Company Entry/Edit

Introduction, cont.

IP Inpatient - Allows entry/edit of inpatient benefits data.

OP Outpatient - Allows entry/edit of outpatient benefits data.

MH Mental Health - Allows entry/edit of mental health inpatient and outpatient benefits data.

HH Home Health - Allows entry/edit of home health care benefits data.

HS Hospice - Allows entry/edit of hospice benefits data.

RH Rehab - Allows entry/edit of rehabilitation benefits data.

IV IV Mgmt. - Allows entry/edit of intravenous management benefits data.

EA Edit All - Lists editable fields line by line for quick data entry.

CY Change Year - Allows you to change to another benefit year.

View/Edit Plan Screen

This screen displays plan information for viewing/editing including utilization review info, plan coverage limitations, annual benefit dates, user information, and plan comments.

Actions

PI Policy Information - Allows entry/edit of maximum out of pocket and ambulance coverage.

UI UR Info - Allows entry/edit of utilization review information.

CV Add/Edit Coverage - Allows you to add or edit coverage limitations for a specific plan.

PC Plan Comments - Allows editing of comments for the plan.

Insurance Company Entry/Edit

Introduction, cont.

IP Inpatient - Allows entry/edit of inpatient benefits data.

AB Annual Benefits - (accesses Annual Benefits Editor screen) - Used to enter annual benefits data for the selected policy.

CP Change Plan - Allows you to select another plan for this insurance company without having to exit back to the previous screen.

Although this option is not locked, the MCCR System Definition Menu is locked with the IB SUPERVISOR security key.

Example

```
Insurance Company Editor    May 30, 1997 10:32:43     Page:    1 of    5
Insurance Company Information for: FOUNDATION HEALTH
Type of Company: CHAMPUS                    Currently Active

                            Billing Parameters
  Signature Required?: NO                    Attending Phys. ID:
           Reimburse?: WILL REIMBURSE        Hosp. Provider No.:
    Mult. Bedsections:                        Primary Form Type:
     Diff. Rev. Codes:                            Billing Phone:
       One Opt. Visit: NO                    Verification Phone:
  Amb. Sur. Rev. Code:                       Precert Comp. Name:
  Rx Refill Rev. Code:                            Precert Phone:
    Filing Time Frame:                               Bin Number:



+         Enter ?? for more actions                                  >>>
BP  Billing Parameters    AO  Appeals Office        AI  (In)Activate Company
MM  Main Mailing Address  IO  Inquiry Office        CC  Change Insurance Co.
IC  Inpt Claims Office    RE  Remarks               DC  Delete Company
OC  Opt Claims Office     SY  Synonyms              PL  Plans
PC  Prescr Claims Of      EA  Edit All              EX  Exit
Select Action: Next Screen//   BP   Billing Parameters


SIGNATURE REQUIRED ON BILL?: NO//   <RET>
REIMBURSE?: WILL REIMBURSE//   <RET>
ALLOW MULTIPLE BEDSECTIONS:   <RET>
DIFFERENT REVENUE CODES TO USE:   <RET>
ONE OPT. VISIT ON BILL ONLY:   <RET>
AMBULATORY SURG. REV. CODE:   <RET>
PRESCRIPTION REFILL REV. CODE:   <RET>
```

Insurance Company Entry/Edit

Example, cont.

```
BIN NUMBER:  ??
     This field is used for facilities who are billing CHAMPUS prescription
     charges electronically to the CHAMPUS fiscal intermediary.  The Bin
     number identifies this company as the CHAMPUS FI to the electronic
     billing system so that the claim is correctly routed to the FI.
BIN NUMBER:  <RET>
FILING TIME FRAME:  <RET>
FILING TIME FRAME:  <RET>
ATTENDING PHYSICIAN ID.:  <RET>
HOSPITAL PROVIDER NUMBER:  <RET>
FORM TYPE:  <RET>
TYPE OF COVERAGE: INDEMNITY//  <RET>
BILLING PHONE NUMBER: 518-272-1000//  <RET>
VERIFICATION PHONE NUMBER:  <RET>
Are Precerts Processed by Another Insurance Co.?: NO
         //  <RET>
PRECERTIFICATION PHONE NUMBER:  <RET>...........
```

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MCCR SYSTEM DEFINITION MENU

ENTER/EDIT AUTOMATED BILLING PARAMETERS - U sed to enter or edit the parameters that control automated billing.

AMBULATORY SURGERY MAINTENANCE MENU

PRINT CHECK-OFF SHEET FOR APPOINTMENTS - Allows you to print Ambulatory Surgery Check-Off Sheets by patient name or clinic for a specified appointment date.

PURGE UPDATE FILE - Used to delete all CPT entries in the temporary file, UPDATE BILLABLE AMBULATORY SURGICAL CODE (#350.41) that have been successfully transferred to the permanent file, BILLABLE AMBULATORY SURGICAL CODE (#350.4).

LOCALITY MODIFIER ENTER/EDIT - Allows you to enter or edit division information for a specific effective date which directly affects CPT billing rates.

LIST TRANSFER ERRORS - Produces a listing of all entries in the temporary UPDATE BILLABLE AMBULATORY SURGICAL CODE file (#350.41) that have not yet transferred to the permanent BILLABLE AMBULATORY SURGICAL CODE file (#350.4).

DELETE/LIST INACTIVE CODES ON CHECK-OFF SHEETS - Lists and deletes CPT codes that are AMA (American Medical Association) inactive or nationally, locally, and billing inactive from check-off sheets.

BUILD CPT CHECK-OFF SHEET - Allows you to build a new CPT check-off sheet or edit an existing one.

AMBULATORY SURGERY RATE EDIT - Allows you to enter or edit entries in the CPT RATE GROUP BILLING file.

CHECK OFF SHEET PRINT - Allows you to print Ambulatory Surgery Check-Off Sheets that have been set up through the Build CPT Check-off Sheet option.

RUN AMB. SURG. UPDATE - Used to transfer CPT (Current Procedural Terminology) codes from the temporary UPDATE BILLABLE AMBULATORY SURGICAL CODE file (#350.41) to the permanent BILLABLE AMBULATORY SURGICAL CODE file (#350.4).

CHARGE MASTER MENU

ENTER/EDIT CHARGE MASTER - Used for the maintenance of Third Party rates and charges. It contains the List Manager screens which display all rate elements/fields.

PRINT CHARGE MASTER - Provides reports for all elements of the Charge Master and maintenance of Third Party rates.

FAST ENTER OF NEW BILLING RATES - This option is designed to allow quick entry of new rates into the Charge Master for Interagency and Tortiously Liable Billing Rates.

DELETE CHARGES FROM THE CHARGE MASTER - Used to delete charges from a Charge Set that are no longer needed.

INACTIVATE/LIST INACTIVE CODES IN CHARGE MASTER - This option searches the charges in the Charge Master for inactive CPT codes. It then inactivates all charges associated with those inactive CPT codes.

ENTER/EDIT BILLING RATES - Used to edit revenue code rates for each bedsection, per diem rates, the Medicare deductible (this is the only place the Medicare deductible is entered), the HCFA ambulatory surgery rates, and pharmacy copayment amounts that are used in the automatic calculation of costs when preparing a third party bill.

FAST ENTER OF NEW BILLING RATES - Designed to facilitate the rapid entry of billing rates for a fiscal year that will be used in the automatic calculation of costs when preparing a third party bill.

FLAG STOP CODES/DISPOSITIONS/CLINICS - Used to flag/unflag those stop codes and dispositions which should not be billed.

INSURANCE COMPANY ENTRY/EDIT - Used to enter new insurance companies into the INSURANCE COMPANY file and edit data on existing companies.

LIST FLAGGED STOP CODES/DISPOSITIONS/CLINICS - Produces a listing of all stop codes, dispositions, and clinics which have been flagged as not being billable for Means Test billing.

BILLING RATES LIST - Prints a list of billing rates by effective date for a selected date range.

MCCR SITE PARAMETER ENTER/EDIT - Allows you to define and edit the MCCR site specific billing parameters.

UPDATE RATE TYPE FILE - Used to add new entries to the RATE TYPE file or to edit existing entries.

MCCR SITE PARAMETER DISPLAY/EDIT - Consolidates parameters from the Enter/Edit IB Site Parameter, MCCR Site Parameter Enter/Edit, Claims Tracking Parameter Edit, and Enter/Edit Automated Billing Parameters options into one option.

THIRD PARTY JOINT INQUIRY - Provides information needed to answer questions from insurance carriers regarding specific bills or episodes of care.

THIRD PARTY BILLING MENU - Option overviews are located under Section 1, Billing Clerk's Menu.

UNBILLED AMOUNTS MENU

RE-GENERATE AVERAGE BILL AMOUNTS - Used to rebuild and store the monthly and yearly counts and dollar amounts of inpatient and outpatient bills for a single month.

RE-GENERATE UNBILLED AMOUNTS REPORT - Used to regenerate the Unbilled Amounts Report for a single month.

SEND TEST UNBILLED AMOUNTS BULLETIN - Allows you to send a test mail message to the mail group receiving the unbilled amounts messages.

VIEW UNBILLED AMOUNTS - Used to view previously computed unbilled amounts without having to re-compile the data.

Management Reports (Billing) Menu
Rank Insurance Carriers By Amount Billed

Example, cont.

Ranking Of The Top 9 Insurance Carriers By Total Amount Billed

Facility: ALBANY (633) Run Date: 05/24/95
Date Range: 10/01/93 thru 05/24/95 Page: 1
** - denotes an inactive company

Rank		Insurance Carrier	Total Amt Billed
1.		HEALTH INSURANCE LTD. 23 3RD ST Suite 450 TROY, NEW YORK 12181	$215,868.78
2.		AETNA 123 Ave Of The Moons LOS ANGELES, CALIFORNIA 00098	$35,843.63
3.	**	GHI 675 THIRD AVE TROY, NEW YORK 12345	$4,902.00
4.		AETNA 789 UBIQUITOUS STREET SALT LAKE CITY, UTAH 44432	$4,048.06
5.		AETNA 567 RAIN AVE. SIOUX CITY, IOWA 33321	$3,153.24
6.		PRUDENTIAL 123 MAIN STREET YORKVILLE, NEW YORK 33343	$2,862.43
7.		AETNA 123 MASON STREET NEW YORK, NEW YORK 11234	$1,576.00
8.		STRAIT INSURANCE 98 PARK AVE SAN ANTONIO, TEXAS 43222	$950.00
9.		TRAVELERS-RICHMOND 1234 THOMAS ST. RICHMOND, VIRGINIA 12345	$482.69

Total Amount Billed to all Ranked Carriers: $269,686.83

Management Reports (Billing) Menu
Billing Rates List

The Third Party Tortiously Liable rates have been removed from this report. These rates are now available on the Charge Item Report on the Print Charge Master option.

Introduction

The Billing Rates List option will print a list of billing rates for a selected date range. It is an efficient way to verify that all billing rate entries have been entered correctly.

The output generated by this option displays the CHAMPVA, Health Care Finance Administration (HCFA) ambulatory surgery rates, Medicare deductible, and copayments. The effective date, amount (basic rate), and additional amount will be shown for each rate, if applicable. Certain ambulatory surgeries may be billed at the HCFA rate. The amount shown (if any) in the "Additional Amount" column is an extra amount which may be charged for all procedures within that rate group. The amount shown under "Inpatient Per Diem" and "NHCU Per Diem" is the daily charge for Category C patients.

Any billing rate that is effective for any date within the selected range is displayed. If more than one rate was effective within the date range, both rates are displayed.

Management Reports (Billing) Menu
Billing Rates List

Example

```
Enter Beginning Date:  1/1  (JAN 01, 1997)
Enter Ending Date:  t  (JUN 11, 1997)
DEVICE: HOME//  <RET>  LAT    RIGHT MARGIN: 80//   <RET>

JUN 11,1997       ***Billing Rates Listing***                    PAGE 1
                            Rates in effect from: JAN 01, 1997
                                              to: JUN 11, 1997
================================================================================

CHAMPVA LIMIT
  Effective Date      Amount    Additional Amount
  OCT 01, 1991        $25

CHAMPVA SUBSISTENCE
  Effective Date      Amount    Additional Amount
  OCT 01, 1994        $9.50
HCFA AMB. SURG. RATE 1
  Effective Date      Amount    Additional Amount
  JAN 01, 1992        $285

HCFA AMB. SURG. RATE 2
  Effective Date      Amount    Additional Amount
  JAN 01, 1992        $382



Enter RETURN to continue or '^' to exit:   <RET>

JUN 11,1997       ***Billing Rates Listing***                    PAGE 2
                            Rates in effect from: JAN 01, 1997
                                              to: JUN 11, 1997
================================================================================

HCFA AMB. SURG. RATE 3
  Effective Date      Amount    Additional Amount
  JAN 01, 1992        $438

HCFA AMB. SURG. RATE 4
  Effective Date      Amount    Additional Amount
  JAN 01, 1992        $539

HCFA AMB. SURG. RATE 5
  Effective Date      Amount    Additional Amount
  JAN 01, 1992        $615

HCFA AMB. SURG. RATE 6
  Effective Date      Amount    Additional Amount
  JAN 01, 1992        $580      $200



Enter RETURN to continue or '^' to exit:   <RET>
```

Management Reports (Billing) Menu
Billing Rates List

Example, cont.

```
JUN 11,1997       ***Billing Rates Listing***                    PAGE 3
                           Rates in effect from: JAN 01, 1997
                                             to: JUN 11, 1997
================================================================================

HCFA AMB. SURG. RATE 7
  Effective Date      Amount    Additional Amount
  JAN 01, 1992        $853

HCFA AMB. SURG. RATE 8
  Effective Date      Amount    Additional Amount
  JAN 01, 1992        $705      $200

HCFA AMB. SURG. RATE 9
  Effective Date      Amount    Additional Amount
  JAN 01, 1992        $0

INPATIENT PER DIEM
  Effective Date      Amount    Additional Amount
  OCT 01, 1990        $10



Enter RETURN to continue or '^' to exit:

JUN 11,1997       ***Billing Rates Listing***                    PAGE 4
                           Rates in effect from: JAN 01, 1997
                                             to: JUN 11, 1997
================================================================================

MEDICARE DEDUCTIBLE
  Effective Date      Amount    Additional Amount
  JAN 01, 1996        $736

NHCU PER DIEM
  Effective Date      Amount    Additional Amount
  OCT 01, 1990        $5

NSC PHARMACY COPAY
  Effective Date      Amount    Additional Amount
  OCT 01, 1992        $2
  JUN 09, 1997        $5.00     $2.00

SC PHARMACY COPAY
  Effective Date      Amount    Additional Amount
  OCT 01, 1990        $2


Enter RETURN to continue or '^' to exit:
```

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Management Reports (Billing) Menu
Revenue Code Totals by Rate Type

INTRODUCTION

The Revenue Code Totals by Rate Type option prints the total amount billed by revenue code for a selected rate type and date range.

Circular 10-91-012 requires that revenue code 100 be used for the $10.00 hospital per diem and revenue code 550 be used for the $5.00 nursing home per diem. The purpose of this report is to allow sites to calculate the total amount billed for $5 (revenue code 550) and $10 (revenue code 100) Means Test per diems for input to AMIS segments 295 and 296.

You may print a list of all revenue codes (for the date range) with the associated patient name, patient ID, bill #, and individual amount or a summary list which provides the total amount and total number of bills for each code. It should be noted that because more than one revenue code may appear on a bill, the total number of bills does not equal the sum of the number of bills containing a specific revenue code.

The chart on the following page shows the steps and prompts involved in using this option.

MCCR System Definition Menu
Ambulatory Surgery Maintenance Menu
Run Amb. Surg. Update

EXAMPLE
The following is an example of what might appear on your screen while using this option. User responses are shown in boldface type.

```
Transfer HCFA updates to the Permanent BASC File


This option transfers the HCFA updates from the temporary BASC file to the
permanent BASC file.
Proceed with transfer?  Y  YES

Beginning transfer, this could take some time.   Please wait...

Transferring HCFA updates to permanent BASC file.

Transfer complete: 923 Entries created in 409.71
                   91 Entries created in 350.4
                   91 Entries in 350.4 "stuffed"

                   0 Codes already have entries for given effective date
                   9 Codes unable to transfer
```

MCCR System Definition Menu
Enter/Edit Billing Rates

Entry/edit of the REVENUE CODE RATES is no longer allowed. If selected, the following message is displayed, "This option is no longer active. Please use the Enter/Edit Charge Master option."

 This option is locked with the IB SUPERVISOR security key.

Introduction

The Enter/Edit Billing Rates option is used to edit billing rates for per diem rates; the Medicare deductible (this is the only place the Medicare deductible is entered); the HCFA ambulatory surgery rates, pharmacy copayment amounts, and CHAMPVA subsistence rates that are used in the automatic calculation of costs when preparing a third party bill.

Although the option allows entry of new rates, it should only be used for editing and for the entry of duplicate rates. Duplicate rates are those where two different rates are used for the same revenue code/bedsection/effective date dependent on payor. All other new billing rates should be entered through the Fast Enter New Billing Rates option.

If YES is answered at the "NON-STANDARD RATE" prompt, that billing rate will only be used with insurance companies where the selected revenue code has been listed in the DIFFERENT REVENUE CODES TO USE field of the INSURANCE COMPANY file.

You may enter an additional amount as well as the basic amount to be charged for all rates. This is a fixed additional dollar amount that will be added to the basic charge after it has been computed. An example would be the additional charge of $200 added to HCFA Ambulatory Surgery rate groups for inter-ocular lens implants.

Accuracy in entering billing rates is critical. Incorrect entries will result in erroneous bills. After new rates are entered, it is suggested you print the Billing Rates List (Billing Rates List option on the Management Reports Menu) to verify that all entries are correctly recorded.

MCCR System Definition Menu
Enter/Edit Billing Rates

Example

```
                          Enter/Edit Billing Rates

CHOOSE FROM:
    1               REVENUE CODE RATES
    2               PER DIEM RATES
    3               MEDICARE DEDUCTIBLE
    4               HCFA AMB. SURG. RATES
    5               RX CO-PAYMENT
    6               CHAMPVA SUBSISTENCE RATES


Select Billing Rate Type:  1  REVENUE CODE RATES

Select BEDSECTION:  1   ALCOHOL AND DRUG TREATMENT   8

Select BILLING RATE EFFECTIVE DATE:   10 1 90   OCT  1, 1990  ALCOHOL AND DRUG
TREATMENT   101   $250.00   YES,ACTIVE
EFFECTIVE DATE: OCT 1,1990//   <RET>
BILLING BEDSECTION: ALCOHOL AND DRUG TREATMENT//    <RET>
REVENUE CODE: 101//  <RET>
AMOUNT: $450.00//  400.00
ACTIVE: YES,ACTIVE//  <RET>
PAYORS TO USE WITH: INSURANCE CO.//   <RET>
NON-STANDARD RATE:  <RET>

Select BILLING RATE EFFECTIVE DATE: "  10 1 90"   OCT 01,1990
   ARE YOU ADDING 'OCT 1,1990' AS A NEW BILLING RATES?    Y   (YES)
EFFECTIVE DATE: OCT 1,1990//   <RET>
BILLING BEDSECTION: ALCOHOL AND DRUG TREATMENT//    <RET>
REVENUE CODE:  101   101  ALL INCL R&B  ALL INCLUSIVE ROOM & BOARD
AMOUNT:  350.00
ACTIVE:  1   YES,ACTIVE
PAYORS TO USE WITH:  opc  ALL BUT INSURANCE CO.'S
NON-STANDARD RATE:  <RET>

Select BILLING RATE EFFECTIVE DATE:   <RET>

Select BEDSECTION:  <RET>
```

MCCR System Definition Menu
Enter/Edit Billing Rates

Example, cont.

```
                          Enter/Edit Billing Rates

CHOOSE FROM:
    1               REVENUE CODE RATES
    2               PER DIEM RATES
    3               MEDICARE DEDUCTIBLE
    4               HCFA AMB. SURG. RATES
    5               RX CO-PAYMENT
    6               CHAMPVA SUBSISTENCE RATES

Select Billing Rate Type:
```

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MCCR System Definition Menu
Flag Stop Codes/Clinics for Third Party

EXAMPLE
The following example is an example of what may appear on your screen while using this option. User responses appear in boldface type.

```
Flag Stop Codes and Clinics for Third Party Billing
============================================================================
FOR THIRD PARTY BILLING, THIS OPTION IS USED TO SET UP:
1. INDIVIDUAL OR A GROUP OF STOP CODES OR CLINICS AS:
   a. NON-BILLABLE OR BILLABLE.
      A Stop/Clinic is assumed billable until it is flagged as non-billable.
   b. IGNORED BY THE AUTO BILLER.  Stops the auto biller from creating
      bills for specified billable Stops/Clinics.
2. ALL CLINICS TO BE:
   a. IGNORED BY THE AUTO BILLER.  Stops the auto biller from creating bills
      for ALL clinics.  Should only be used if the outpatient auto biller
      is on but only a small number of Clinics should be auto billed.
   b. BILLED BY THE AUTO BILLER.  Resets all Clinics to be auto billed.
Use of this option will have an immediate effect on your billing operations
so you should have your work pre-planned before using this option.
============================================================================

     Select one of the following:

          S         STOP CODES
          C         CLINICS
          A         ALL CLINICS

Enter your choice:  STOP CODES

============================================================================
You may now enter the clinic stop codes that you wish to flag.  Please note
all clinic stop codes that you select will be assigned the same effective
date and billable status and auto bill status.
============================================================================

Select CLINIC STOP CODE:  GENERAL MEDICINE          301
Next CLINIC STOP CODE:  <RET>

Is this clinic stop code Non-Billable for Third Party Billing?     NO

Should the Third Party Auto Biller create bills for this clinic stop code?     NO
Please enter the date this should become effective:    T  (OCT 01, 1996)

============================================================================
GENERAL MEDICINE

Effective Oct 01, 1996 the above clinic stop codes will be billable
and will NOT have bills created by the Third Party auto biller.

Is this correct, is it okay to proceed and file these entries?     YES

Filing these CLINIC STOP CODE entries...  . done!
```

MCCR System Definition Menu
Insurance Company Entry/Edit

Now displays NO for ALLOW MULTIPLE BEDSECTIONS only if the field has been answered NO. Previously, NO was assumed if there was no answer in the field.

The Billing Parameters action of this option has been modified so that the user may enter the BIN number for an insurance carrier. This number ID is also displayed in the Insurance Company Editor screen. The BIN number must be entered for the company which is the Tricare FI (Fiscal Intermediary - the company with which the Tricare patient holds their Tricare insurance coverage). The BIN number is passed to the RNA package and transmitted to the electronic switch company, where it is used to determine the address for forwarding to the FI. If the BIN number is not entered, pharmacy claims will not be passed to the RNA system for submission to the FI.

Only national, print-type forms may be selected at the FORM TYPE field. A locally defined form name cannot be selected. The FORM TYPE field is used to determine the basic bill format, not the specific form that will print for the insurance company.

Introduction

The Insurance Company Entry/Edit option is used to enter new insurance companies into the INSURANCE COMPANY file and edit data on existing companies. An insurance company must be in the INSURANCE COMPANY file before it can be entered into a patient's record.

When entering new insurance companies, you will be prompted for the company street address, city, and whether or not the company will reimburse for treatment.

Following is a listing of the actions found on the screen in this option and a brief description of each. Once an action has been selected, <??> may be entered at most of the prompts that appear for lists of acceptable responses or instruction on how to respond.

Insurance Company Editor Screen

Once the insurance company is selected, this screen is displayed listing the following groups of information for that company: billing parameters, main mailing address, inpatient claims office data, outpatient claims office data, prescription claims office data, appeals office data, inquiry office data, remarks, and synonyms.

MCCR System Definition Menu
Insurance Company Entry/Edit

Introduction, cont.

BP Billing Parameters - Allows you to add/edit the billing parameters for the selected insurance company.

MM Main Mailing Address - Allows you to add/edit the company's main mailing address. The address entered here will automatically be entered for the other office addresses.

IC Inpt Claims Office - Allows you to add/edit the company's inpatient claims office name, address, phone and fax numbers.

OC Opt Claims Office - Allows you to add/edit the company's outpatient claims office name, address, phone and fax numbers.

PC Prescr Claims Of - Allows you to add/edit the company's prescription claims office name, address, phone and fax numbers.

AO Appeals Office - Allows you to add/edit the company's appeals office name, address, phone and fax numbers.

IO Inquiry Office - Allows you to add/edit the company's inquiry office name, address, phone and fax numbers.

RE Remarks - Allows the user to enter comments concerning the selected insurance company.

SY Synonyms - Allows you to add/edit any synonyms for the selected company.

EA Edit All - Lists editable fields line by line for quick data entry.

AI (In)Activate Company - Allows you to activate/inactivate the selected insurance company. This may be used to inactivate duplicate companies in the system. When an insurance company is no longer valid, it is important to inactivate the company rather than delete it from the system. The IB INSURANCE SUPERVISOR security key is required. Once a company has been inactivated, it may not be selected when entering billing information.

You may also obtain a report of patients insured by a given company through this action.

MCCR System Definition Menu
Insurance Company Entry/Edit

Introduction, cont.

CC Change Insurance Co. - Allows you to change to another company without returning to the beginning of the option.

DC Delete Company - Allows you to delete an entry from the INSURANCE COMPANY (#36) file. If claims have been submitted to the company, another company must be selected in which to point all claims and receivables information.

PL Plans (accesses Insurance Plan List screen) - Allows you to display and change plan attributes associated with the insurance company.

Insurance Plan List Screen
This screen lists all plans (active and inactive, group and individual) for the selected insurance company.

Actions

VP View/Edit Plan (accessesView/Edit Plan screen)- Allows you to display /change plan detailed information.

IP Inactive Plan - Allows you to inactivate an insurance plan, or move subscribers from multiple insurance plans into one master plan.

AB Annual Benefits - (accesses Annual Benefits Editor screen) - Used to enter annual benefits data for the selected policy.

Annual Benefits Editor Screen
Once the benefit year is selected, this screen is displayed listing all the benefits for the selected insurance policy and benefit year. Benefit categories may include inpatient benefits, outpatient benefits, mental health, home health care, hospice, rehabilitation, and IV management.

Actions

PI Policy Information - Allows entry/edit of maximum out of pocket and ambulance coverage.

MCCR System Definition Menu
Insurance Company Entry/Edit

Introduction, cont.

IP Inpatient - Allows entry/edit of inpatient benefits data.

OP Outpatient - Allows entry/edit of outpatient benefits data.

MH Mental Health - Allows entry/edit of mental health inpatient and outpatient benefits data.

HH Home Health - Allows entry/edit of home health care benefits data.

HS Hospice - Allows entry/edit of hospice benefits data.

RH Rehab - Allows entry/edit of rehabilitation benefits data.

IV IV Mgmt. - Allows entry/edit of intravenous management benefits data.

EA Edit All - Lists editable fields line by line for quick data entry.

CY Change Year - Allows you to change to another benefit year.

View/Edit Plan Screen
This screen displays plan information for viewing/editing including utilization review info, plan coverage limitations, annual benefit dates, user information, and plan comments.

Actions

PI Policy Information - Allows entry/edit of maximum out of pocket and ambulance coverage.

UI UR Info - Allows entry/edit of utilization review information.

CV Add/Edit Coverage - Allows you to add or edit coverage limitations for a specific plan.

PC Plan Comments - Allows editing of comments for the plan.

MCCR System Definition Menu
Insurance Company Entry/Edit

Introduction, cont.

IP Inpatient - Allows entry/edit of inpatient benefits data.

AB Annual Benefits - (accesses Annual Benefits Editor screen) - Used to enter annual benefits data for the selected policy.

CP Change Plan - Allows you to select another plan for this insurance company without having to exit back to the previous screen.

Although this option is not locked, the MCCR System Definition Menu is locked with the IB SUPERVISOR security key.

Example

```
Insurance Company Editor    May 30, 1997 10:32:43     Page:    1 of    5
Insurance Company Information for: FOUNDATION HEALTH
Type of Company: CHAMPUS                      Currently Active

                            Billing Parameters
  Signature Required?: NO                     Attending Phys. ID:
           Reimburse?: WILL REIMBURSE         Hosp. Provider No.:
    Mult. Bedsections:                         Primary Form Type:
     Diff. Rev. Codes:                             Billing Phone:
        One Opt. Visit: NO                     Verification Phone:
  Amb. Sur. Rev. Code:                         Precert Comp. Name:
  Rx Refill Rev. Code:                              Precert Phone:
    Filing Time Frame:                                 Bin Number:



+         Enter ?? for more actions                                  >>>
BP  Billing Parameters    AO  Appeals Office        AI  (In)Activate Company
MM  Main Mailing Address  IO  Inquiry Office        CC  Change Insurance Co.
IC  Inpt Claims Office    RE  Remarks               DC  Delete Company
OC  Opt Claims Office     SY  Synonyms              PL  Plans
PC  Prescr Claims Of      EA  Edit All              EX  Exit
Select Action: Next Screen//   BP   Billing Parameters


SIGNATURE REQUIRED ON BILL?: NO//   <RET>
REIMBURSE?: WILL REIMBURSE//   <RET>
ALLOW MULTIPLE BEDSECTIONS:   <RET>
DIFFERENT REVENUE CODES TO USE:   <RET>
ONE OPT. VISIT ON BILL ONLY:   <RET>
AMBULATORY SURG. REV. CODE:   <RET>
PRESCRIPTION REFILL REV. CODE:   <RET>
```

MCCR System Definition Menu
Insurance Company Entry/Edit

Example, cont.

```
BIN NUMBER:  ??
     This field is used for facilities who are billing CHAMPUS prescription
     charges electronically to the CHAMPUS fiscal intermediary.  The Bin
     number identifies this company as the CHAMPUS FI to the electronic
     billing system so that the claim is correctly routed to the FI.
BIN NUMBER:  <RET>
FILING TIME FRAME:  <RET>
FILING TIME FRAME:  <RET>
ATTENDING PHYSICIAN ID.:  <RET>
HOSPITAL PROVIDER NUMBER:  <RET>
FORM TYPE:  <RET>
TYPE OF COVERAGE: INDEMNITY//  <RET>
BILLING PHONE NUMBER: 518-272-1000//  <RET>
VERIFICATION PHONE NUMBER:  <RET>
Are Precerts Processed by Another Insurance Co.?: NO
        //  <RET>
PRECERTIFICATION PHONE NUMBER:  <RET>.....
```

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MCCR System Definition Menu
List Flagged Stop Codes/Clinics for Third Party

EXAMPLE, cont.

```
================================================================================
               LIST OF CLINICS FLAGGED FOR THIRD PARTY BILLING
                              As Of: 10/01/96
                                                              Page: 3
                                                         Run Date: 10/01/96
================================================================================

                                  NON-BILLABLE

No clinics are flagged as NON-BILLABLE

                                NOT AUTO BILLED

GENERAL MEDICAL
```

MCCR System Definition Menu
Billing Rates List

The Third Party Tortiously Liable rates have been removed from this report. These rates are now available on the Charge Item Report on the Print Charge Master option.

Introduction

The Billing Rates List option will print a list of billing rates for a selected date range. It is an efficient way to verify that all billing rate entries have been entered correctly.

The output generated by this option displays the CHAMPVA, Health Care Finance Administration (HCFA) ambulatory surgery rates, Medicare deductible, and copayments. The effective date, amount (basic rate), and additional amount will be shown for each rate, if applicable. Certain ambulatory surgeries may be billed at the HCFA rate. The amount shown (if any) in the "Additional Amount" column is an extra amount which may be charged for all procedures within that rate group. The amount shown under "Inpatient Per Diem" and "NHCU Per Diem" is the daily charge for Category C patients.

Any billing rate that is effective for any date within the selected range is displayed. If more than one rate was effective within the date range, both rates are displayed.

MCCR System Definition Menu
Billing Rates List

Example

```
Enter Beginning Date:  1/1  (JAN 01, 1997)
Enter Ending Date:  t  (JUN 11, 1997)
DEVICE: HOME//  <RET>  LAT    RIGHT MARGIN: 80//   <RET>

JUN 11,1997       ***Billing Rates Listing***                    PAGE 1
                            Rates in effect from: JAN 01, 1997
                                              to: JUN 11, 1997
================================================================================

CHAMPVA LIMIT
  Effective Date      Amount    Additional Amount
  OCT 01, 1991        $25

CHAMPVA SUBSISTENCE
  Effective Date      Amount    Additional Amount
  OCT 01, 1994        $9.50
HCFA AMB. SURG. RATE 1
  Effective Date      Amount    Additional Amount
  JAN 01, 1992        $285

HCFA AMB. SURG. RATE 2
  Effective Date      Amount    Additional Amount
  JAN 01, 1992        $382



Enter RETURN to continue or '^' to exit:   <RET>

JUN 11,1997       ***Billing Rates Listing***                    PAGE 2
                            Rates in effect from: JAN 01, 1997
                                              to: JUN 11, 1997
================================================================================

HCFA AMB. SURG. RATE 3
  Effective Date      Amount    Additional Amount
  JAN 01, 1992        $438

HCFA AMB. SURG. RATE 4
  Effective Date      Amount    Additional Amount
  JAN 01, 1992        $539

HCFA AMB. SURG. RATE 5
  Effective Date      Amount    Additional Amount
  JAN 01, 1992        $615

HCFA AMB. SURG. RATE 6
  Effective Date      Amount    Additional Amount
  JAN 01, 1992        $580      $200



Enter RETURN to continue or '^' to exit:   <RET>
```

MCCR System Definition Menu
Billing Rates List

Example, cont.

```
JUN 11,1997       ***Billing Rates Listing***                    PAGE 3
                           Rates in effect from: JAN 01, 1997
                                             to: JUN 11, 1997
================================================================================

HCFA AMB. SURG. RATE 7
  Effective Date      Amount    Additional Amount
  JAN 01, 1992        $853

HCFA AMB. SURG. RATE 8
  Effective Date      Amount    Additional Amount
  JAN 01, 1992        $705      $200

HCFA AMB. SURG. RATE 9
  Effective Date      Amount    Additional Amount
  JAN 01, 1992        $0

INPATIENT PER DIEM
  Effective Date      Amount    Additional Amount
  OCT 01, 1990        $10



Enter RETURN to continue or '^' to exit:

JUN 11,1997       ***Billing Rates Listing***                    PAGE 4
                           Rates in effect from: JAN 01, 1997
                                             to: JUN 11, 1997
================================================================================

MEDICARE DEDUCTIBLE
  Effective Date      Amount    Additional Amount
  JAN 01, 1996        $736

NHCU PER DIEM
  Effective Date      Amount    Additional Amount
  OCT 01, 1990        $5

NSC PHARMACY COPAY
  Effective Date      Amount    Additional Amount
  OCT 01, 1992        $2
  JUN 09, 1997        $5.00     $2.00

SC PHARMACY COPAY
  Effective Date      Amount    Additional Amount
  OCT 01, 1990        $2


Enter RETURN to continue or '^' to exit:
```

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MCCR System Definition Menu
MCCR Site Parameter Enter/Edit

INTRODUCTION The MCCR Site Parameter Enter/Edit option allows the user to define and edit the MCCR site specific billing parameters. The parameters are displayed upon entering the option. They are divided into groups for editing. Each group is labeled with a number to the left of the data items. Some values may be filled in by the system.

Group 1 The medical center name is automatically filled in and is not editable. The federal tax number is the tax ID# assigned to the medical center and is a required field. There may be more than one Blue Cross/Blue Shield provider number assigned to a site for different categories of care. The main Blue Cross/Blue Shield provider number should be entered here. This is a required field. The Medicare provider number is furnished to your facility by Medicare. The MAS Service Pointer is Medical Administration Service the way it is entered in your HOSPITAL SERVICE file. The default division will appear as the default to the division question when entering Billable Ambulatory Surgical Codes on a bill.

Group 2 The name and title of bill signer will appear on the third party billing form. The billing supervisor name does not appear on the form. This is used in conjunction with the Bill Cancellation and Bill Disapproval Mail Groups. If these groups are not specified, the billing supervisor will be one of the few recipients of both messages.

Group 3 The MULTIPLE FORM TYPES parameter should be set to YES if your facility uses more than one health insurance billing form. UB forms and HCFA-1500 are the forms currently available. If this field is left blank or answered NO, only UB forms will be allowed. Beginning with version 1.5 of Integrated Billing, the review step of creating a bill has been eliminated. If the CAN INITIATOR AUTHORIZE parameter is set to YES and the initiator holds the IB AUTHORIZE security key, the initiator of the bill will be allowed to authorize the bill. If this parameter is set to NO, another user who holds the IB AUTHORIZE key will have to authorize the bill.

MCCR System Definition Menu
MCCR Site Parameter Display/Edit

A new set of parameters has been added to the IB Site Parameters screen. These parameters are used to configure the Tricare Pharmacy billing interface, and must be set prior to starting the background filer. The new parameters are described in the Introduction.

Parameter Group	Security Key Required
IB Site Parameters	IB SUPERVISOR
Claims Tracking Parameters	IB CLAIMS SUPERVISOR
Third Party Auto Billing Parameters	IB SUPERVISOR

Introduction

This option consolidates parameters from the Enter/Edit IB Site Parameters, MCCR Site Parameter Enter/Edit, Claims Tracking Parameter Edit, and Enter/Edit Automated Billing Parameters options. The initial screen lists three parameter groups.

Following is a list of the screens, the actions they provide, and a brief description of each action. Actions shown in *italics* access other screens.

MCCR Site Parameters Screen

IB Site Parameters - accesses the IB Site Parameter screen which displays general Integrated Billing site parameters.

Claims Tracking Parameters - accesses the Claims Tracking Parameters screen which displays parameters specific to the set-up and control of Claims Tracking functions.

Third Party Auto Billing Parameters - accesses the Automated Billing Parameters screen which displays the control parameters for the Third Party Automated Biller.

MCCR System Definition Menu
MCCR Site Parameter Display/Edit

Introduction, cont.

IB Site Parameters Screen

Descriptions for most of the parameters included on this screen can be found in the Enter/Edit IB Site Parameters and MCCR Site Parameter Enter/Edit option documentation. Following is a description of the six parameters (group 12) used to configure the Tricare Pharmacy billing interface that are user set. The other seven parameters in this group that appear on the right hand side of the screen are set by the system.

Rx Billing Port - This is the logical port that is opened to establish a TCP/IP connection with the RNA package to submit Pharmacy claims. This is normally a number between 2000 and 10000. The number that is selected is programmed into the RNA package, as this is the port that the RNA package constantly polls for input from V*ISTA*. The Billing port must be entered to start the billing engine.

AWP Update Port - This is the logical port that is opened to establish a TCP/IP connection with the RNA package to receive AWP updates. This is normally a number between 2000 and 10000. This number is also programmed into the RNA package, as it is the port through which the RNA package transmits the AWP updates. This port number must be different from the Billing port number, or the background job to receive AWP updates will not be queued to run.

TCP/IP Address - This is the TCP/IP address used to reach the RNA package. This address is usually determined by the facility systems manager and supplied to RNA on the Plan Installation Worksheet. This address must be entered to start the billing engine.

Task UCI,VOL - This is UCI and Volume set on which the queued background jobs should run. If this field has no value (i.e., for Alpha sites), the jobs will be queued to run on the current UCI and Volume.

AWP Charge Set This is the Charge Set within the Charge Master which was used to load the AWP. The interface must know which Charge Set should be used to extract a unit price for a specific NDC number (drug). A valid Charge Set must be entered to start the billing engine.

MCCR System Definition Menu
MCCR Site Parameter Display/Edit

Introduction, cont.

Prescriber ID - This is the DEA number assigned to your facility, which you should determine prior to the installation of the RNA package. This number must be submitted with the Pharmacy Billing transaction. The number must be entered to start the billing engine.

Edit Set - This action allows you to view/edit the fields included in the 12 sets displayed.

Claims Tracking Parameters Screen
Descriptions of the parameters included on this screen can be found in the Claims Tracking Parameter Edit option documentation.

Tracking - allows you to edit the data displayed under the Tracking Parameters heading. These parameters control which episodes of care are added to Claims Tracking.

Random Sample - allows you to edit the data displayed under the Random Sample Parameters heading. These parameters control the selection of random samples.

General - allows you to edit the data displayed under the General Parameters heading.

Edit All - allows you to edit all data displayed on the Claims Tracking Parameters screen.

Automated Billing Parameters Screen
Descriptions of the parameters included on this screen can be found in the Enter/Edit Automated Billing Parameters option documentation.

General - allows you to edit the data displayed under the General Parameters heading.

Inpatient - allows you to edit the data displayed under the Inpatient Admission heading. These parameters control if and when inpatient episodes of care are processed by the Third Party automated biller.

MCCR System Definition Menu
MCCR Site Parameter Display/Edit

Introduction, cont.

Outpatient - allows you to edit the data displayed under Outpatient Visit the heading. These parameters control if and when outpatient visits are processed by the Third Party automated biller.

Prescription - allows you to edit the data displayed under the Prescription Refill heading. These parameters control if and when prescription refills are processed by the Third Party automated biller.

Example 1 - MCCR Site Parameters Screen (Main Screen)

```
MCCR Site Parameters          May 13, 1996 10:45:52          Page:    1 of    1
Display/Edit MCCR Site Parameters.
Only authorized persons may edit this data.

 IB Site Parameters                          Claims Tracking Parameters
    Facility Definition                       General Parameters
    Mail Groups                               Tracking Parameters
    Patient Billing                           Random Sampling
    Third Party Billing

 Third Party Auto Billing Parameters
    General Parameters
    Inpatient Admission
    Outpatient Visit
    Prescription Refill

          Enter ?? for more actions
IB  Site Parameter        CT  Claims Tracking       AB  Automated Billing
                                                    EX  Exit Action
Select Action: Quit//  IB   Site Parameter
```

MCCR System Definition Menu
MCCR Site Parameter Display/Edit

Example 2 - IB Site Parameters Screen

```
IB Site Parameters           May 13, 1996 10:49:28          Page:    1 of    3
Only authorized persons may edit this data.

[1] Copay Background Error Mg: IB ERROR
    Copay Exemption Mailgroup: IB ERROR
    Use Alerts for Exemption : YES

[2] Per Diem Start Date      : 01/01/00
    Hold MT Bills w/Ins      : YES
    Suppress MT Ins Bulletin : NO
    Cat C Mailgroup          : IB CAT C

[3] Disapproval Mailgroup    : PTF
    Cancellation Mailgroup   : PTF
    Cancellation Remark      : TESTING CANCELLATION IN MAS

[4] New Insurance Mailgroup  : IB NEW INSURANCE
    Unbilled Mailgroup       : IB UNBILLED AMOUNTS
    Auto Print Unbilled List : NO

+         Enter ?? for more actions
EP  Edit Set                                        EX  Exit Action
Select Action: Next Screen//
```


```
IB Site Parameters           May 13, 1996 10:49:28          Page:    1 of    3
Only authorized persons may edit this data.

[1] Copay Background Error Mg: IB ERROR
    Copay Exemption Mailgroup: IB ERROR
    Use Alerts for Exemption : YES

[2] Per Diem Start Date      : 01/01/00
    Hold MT Bills w/Ins      : YES
    Suppress MT Ins Bulletin : NO
    Cat C Mailgroup          : IB CAT C

[3] Disapproval Mailgroup    : PTF
    Cancellation Mailgroup   : PTF
    Cancellation Remark      : TESTING CANCELLATION IN MAS

[4] New Insurance Mailgroup  : IB NEW INSURANCE
    Unbilled Mailgroup       : IB UNBILLED AMOUNTS
    Auto Print Unbilled List : NO

+         Enter ?? for more actions
EP  Edit Set                                        EX  Exit Action
Select Action: Next Screen//
```

MCCR System Definition Menu
MCCR Site Parameter Display/Edit

Example 3 - Claims Tracking Parameters Screen

```
Claims Tracking Parameters   May 13, 1996 10:52:27          Page:    1 of    1
Only authorized persons may edit this data.

          Tracking Parameters                  Random Sample Parameters
     Track Inpatient: ALL PATIENTS              Medicine Sample: 5
    Track Outpatient: INSURED ONLY          Medicine Admissions: 5
            Track Rx: ALL PATIENTS               Surgery Sample: 5
   Track Prosthetics: INSURED ONLY           Surgery Admissions: 5
  Reports Can Add CT: YES                           Psych Sample: 0
                                                Psych Admissions: 5

          General Parameters
 Initialization Date: 09/01/94
 Use Admission Sheet: YES
       Header Line 1: ALBANY VAMC
       Header Line 2: 113 HOLLAND AVE
       Header Line 3: ALBANY, NY 12305

          Enter ?? for more actions
TP  Tracking                RS  Random Sample          GP  General
EA  Edit All                                           EX  Exit Action
Select Action: Quit//
```

Example 4 - Automated Billing Parameters Screen

```
Automated Billing Parameters  May 13, 1996 10:54:11        Page:    1 of    1
Only authorized persons may edit this data.

          GENERAL PARAMETERS                   INPATIENT ADMISSION
 Auto Biller Frequency: 1                   Automate Billing: YES
   Date Last Completed: 04/30/96               Billing Cycle: 20
      Inpatient Status: Closed                    Days Delay: 1

          OUTPATIENT VISIT                     PRESCRIPTION REFILL
      Automate Billing: YES                 Automate Billing: YES
         Billing Cycle: 10                     Billing Cycle: 3
            Days Delay: 1                         Days Delay: 1

          Enter ?? for more actions
GP  General                 IP  Inpatient              OP  Outpatient
RX  Prescription                                       EX  Exit Action
Select Action: Quit//
```

Third Party Joint Inquiry

EXAMPLE, cont.

```
Patient Eligibility          May 20, 1996 07:45:44          Page:    1 of    1
N10273   JONES,ANDREW  A9281              DOB: 07/07/50   Subsc ID:

             Means Test: CATEGORY A                        Insured: Yes
           Date of Test: 08/24/94                      A/O Exposure:
  Co-pay Exemption Test:                               Rad. Exposure:
           Date of Test:

     Primary Elig. Code: NSC
    Other Elig. Code(s): EMPLOYEE
                         AID & ATTENDANCE
      Service Connected: No
     Rated Disabilities: BONE DISEASE (0%-NSC)
                         DEGENERATIVE ARTHRITIS (40%-NSC)



          Enter ?? for more actions
BC  Bill Charges          AR  Account Profile       VI  Insurance Company
DX  Bill Diagnosis        CM  Comment History       VP  Policy
PR  Bill Procedures       IR  Insurance Reviews     AB  Annual Benefits
CI  Go to Claim Screen    HS  Health Summary        EX  Exit Action
                          AL  Go to Active List
Select Action: Quit//
```

MCCR System Definition Menu
Charge Master Menu
Enter/Edit Charge Master

New Option

The IB SUPERVISOR security key is required to edit.

Introduction

This option is used for the maintenance of Third Party rates and charges. It contains the List Manager screens which display all rate elements/fields. It also includes enter and edit actions so each element can be updated. All edit actions within these screens require the IB SUPERVISOR key.

Screen Descriptions

Introduction Screen
This screen displays a brief description of the elements of the Charge Master that may be viewed/edited through this option. You can display/edit rate types, billing rates, charge sets, and rate schedules.

Rate Type Screen
This is a display/edit screen for Billing Rate Types. All Rate Types currently defined are displayed.

Billing Rates Screen
This is a display/edit screen for Billing Rates. All Billing Rates currently defined are displayed. Part of the definition of a Billing Rate includes what types of item the rate's charges are associated with (Billable Item) and how the charge should be calculated (Charge Method).

Charge Set Screen
This is a display/edit screen for Charge Sets. All Charge Sets currently defined will be displayed. These sets define a sub-set of charges for a Billing Rate. The editing of Charge Sets is restricted to non-critical elements if there are Charge Items defined for the set. Since Revenue Code and Bedsection are required to add charges to a bill, the Default Revenue Code and Default Bedsection are required unless these are defined for each individual Charge Item in the Set.

MCCR System Definition Menu
Charge Master Menu
Enter/Edit Charge Master

Introduction, cont.

Charge Item Screen
This is a display/edit screen for Charge Items. These are the actual records of the item and its corresponding charge. This screen displays items that have active charges in a specified date range for the selected Charge Set. All active Charge Items are displayed for a Charge Set with a Billable Item of Bedsection. However, this screen has been specifically limited to displaying either one CPT or one AWP item at a time. The Effective Date is required for all entries and controls when the charge is active. Each item entry overrides any previously effective charge for the item. A Revenue Code is only required if the Revenue Code for the item is different from the Default Revenue Code of the Charge Set.

Billing Regions Screen
This is a display/edit screen for Billing Regions. All Billing Regions currently defined will be displayed. Billing Regions can be set-up which contain the set of divisions that are billed the same charges for a particular Billing Rate. A Billing Region need only be defined if the charges for a rate vary by region/locality/division and more than one Region will be billed at the site. Currently only Billing Rates based on CPT charges may vary by region.

Rate Schedule Screen
This is a display/edit screen for Rate Schedules. These schedules link the charges and the types of bills they may be added to. All Rate Schedules currently defined are displayed. Rate Schedules must be defined for both inpatient and outpatient charges for a Rate Type and all Charge Sets that may be charged to that type of bill should be added. A Charge Set can set-up to be automatically added to bills or to require user input before the charges are added. The effective dates should only be added if there is a specific date that billing to the payer can start or stop.

MCCR System Definition Menu
Charge Master Menu
Enter/Edit Charge Master

Example

Introduction Screen

```
Introduction                  May 29, 1997 13:09:26          Page:    1 of    1
Only authorized persons may edit this data: IB SUPERVISOR key required to edit.

Rate Type:                Type of Payer.

Billing Rate:             Type of Charge.

Charge Set:               Charges for a specific Billing Rate, broken down by
                          type of event to be billed/charged.

                          Charge Item:       The individual items for a Set
                                             and their charge amounts.
                          Billing Region:    The region or divisions the
                                             charges apply to.

Rate Schedule:            Definition of charges billable to specific payers.
                          Link between Charge Sets and Rate Types.
                          Once the Rate Type is set for a bill, the
                          Rate Schedule will be used to find all charges to
                          add to the bill.
          Enter ?? for more actions
RS  Rate Schedules         RT  Rate Types
CS  Charge Sets            BR  Billing Rates
Select Action: Quit//
```

MCCR System Definition Menu
Charge Master Menu
Enter/Edit Charge Master

Example, cont.

Rate Types Screen

```
Rate Types                    May 29, 1997 13:14:25          Page:    1 of    5
This is a Standard file with entries released nationally.


    Rate Type: CHAMPUS
    Bill Name: CHAMPUS                   AR Category: CHAMPUS
 Abbreviation: CHAMPUS                  Who's Respns: INSURER
 Third Party?: YES                     RI Statement?: YES
     Inactive:                        NSC Statement?: YES

    Rate Type: CHAMPVA REIMB. INS.
    Bill Name: REIMBURSABLE INS.         AR Category: CHAMPVA THIRD PARTY
 Abbreviation: REIM INS                 Who's Respns: INSURER
 Third Party?: YES                     RI Statement?: YES
     Inactive:                        NSC Statement?: YES

    Rate Type: CRIME VICTIM
    Bill Name: THIRD PARTY               AR Category: CRIME OF PER.VIO.
 Abbreviation: CRIME                    Who's Respns: INSURER
 Third Party?: YES                     RI Statement?:
     Inactive:                        NSC Statement?: YES
+         Enter ?? for more actions
ED  Edit Rate Type        MS  Main Screen           EX  Exit
Select Action: Next Screen//
```

MCCR System Definition Menu
Charge Master Menu
Enter/Edit Charge Master

Example, cont.

Billing Rates Screen

```
Billing Rates                  May 29, 1997 13:16:47          Page:    1 of    1

  Rate                                Abbrv       Distrb     Bill Item    Chg Mthd

  INTERAGENCY                         IA          NATIONAL   BEDSECTION   COUNT
  TORTIOUSLY LIABLE                   TORT        NATIONAL   BEDSECTION   COUNT
  VA COST                             VA COST     NATIONAL                VA COST

  AMBULATORY SURGERY                  ASC         LOCAL      CPT          COUNT
  AVERAGE WHOLESALE PRICE             AWP         LOCAL      NDC #        QUANTITY
  CMAC                                CMAC        LOCAL      CPT          COUNT




          Enter ?? for more actions
ED  Edit Rate              MS  Main Screen           EX  Exit
Select Action: Quit//
```

Charge Set Screen

```
Charge Sets                    May 29, 1997 13:19:06          Page:    1 of    2
                                                        Default
 Charge Set                   Bill Event  Type  Rv Cd  Bedsection  Region

         Billing Rate: AMBULATORY SURGERY
AMB SURG REGION 1             PROC              500    OUTPATIENT
AMB SURG REGION 2             PROC              490    OPT DNTL

         Billing Rate: INTERAGENCY
IA-INPT                       INPT BEDS         001
IA-OPT DENTAL                 OPT VST DT        512
IA-OPT VST                    OPT VST DT        500
IA-RX FILL                    RX FILL           257

         Billing Rate: TORTIOUSLY LIABLE
TL-INPT (INCLUSIVE)           INPT BEDS         001
TL-INPT (NPF)                 INPT BEDS   INST
TL-INPT (PF)                  INPT BEDS   PROF  960
TL-CAT C OPT COPAY            OPT VST DT        500
TL-OPT DENTAL                 OPT VST DT        512
+          Enter ?? for more actions
CI  Charge Items          RG  Billing Regions       BR  Billing Rates
ED  Edit Charge Set       MS  Main Screen           EX  Exit
Select Action: Next Screen//
```

MCCR System Definition Menu
Charge Master Menu
Enter/Edit Charge Master

Example, cont.

Charge Items Screen

```
Charge Items                  May 29, 1997 13:25:32          Page:    1 of    1
BEDSECTION items billable to Charge Set TL-INPT (INCLUSIVE) on 05/29/97
Default Revenue Code: 001
  Charge Item                        Unit Charge   Rv Cd    Effective  Inactive
  ALCOHOL AND DRUG TREATMENT           300.00               05/27/97
  BLIND REHABILITATION                 973.00               10/01/96
  GENERAL MEDICAL CARE                1046.00               10/01/96
  INTERMEDIATE CARE                    428.00               10/01/96
  NEUROLOGY                           1014.00               10/01/96
  NURSING HOME CARE                    288.00               10/01/96
  PSYCHIATRIC CARE                     501.00               10/01/96
  REHABILITATION MEDICINE              822.00               10/01/96
  SPINAL CORD INJURY CARE              977.00               10/01/96
  SURGICAL CARE                       1923.00               10/01/96

          Enter ?? for more actions
CD  Change Dates          CI  Change Item           BI  Billing Item Edit
ED  Edit Charge Item      MS  Main Screen           EX  Exit
Select Action: Quit//
```

MCCR System Definition Menu
Charge Master Menu
Enter/Edit Charge Master

Example, cont.

Billing Regions Screen

```
Billing Regions              May 29, 1997 13:34:38          Page:    1 of    1
Sets of divisions covered by the same charges
  Region                 Division

No Billing Regions defined

          Enter ?? for more actions
ED  Edit Region           MS  Main Screen           EX  Exit
Select Action: Quit//
```

Rate Schedules Screen

```
Rate Schedules               May 29, 1997 13:37:01          Page:    1 of    4
Link types of payers and charges
 Schedule             Bill Svs   Charge Set(s)          Effectiv  Inactive Adj

    CRIME VICTIM: Inpatient
CV-INPT               INPT       TL-INPT (NPF)
                                 TL-INPT (PF)

    CRIME VICTIM: Outpatient
CV-OPT                           TL-OPT VST
                                 TL-RX FILL

    DENTAL: Outpatient
DNTL-OPT DENTAL                  TL-OPT DENTAL

    HUMANITARIAN: Inpatient
HMN-INPT              INPT       TL-INPT (INCLUSIVE)

    HUMANITARIAN: Outpatient
HMN-OPT                          TL-OPT VST
                                 TL-RX FILL
+         ~ charges not auto added to bills                              >>>
ED  Edit Schedule         MS  Main Screen           EX  Exit
Select Action: Next Screen//
```

MCCR System Definition Menu
Charge Master Menu
Print Charge Master

New Option

Introduction

This option provides reports for all elements of the Charge Master and maintenance of Third Party rates. The full Charge Item report may be very long if many items have been added, such as CMAC (CHAMPUS Maximum Allowable Charges) charges.

Example

```
Charge Master Reports:


     Select one of the following:

          R         RATE SCHEDULES
          C         CHARGE SETS
          I         CHARGE ITEMS
          B         BILLING RATES
          T         RATE TYPES
          G         BILLING REGIONS
          O         OTHER BILLABLE ITEMS
          X         (OLD RATES FILE)

Select Report:  T  RATE TYPES
Report requires 132 columns.
DEVICE:  <RET> LAT    RIGHT MARGIN: 80//  132

RATE TYPE LIST                                                                  MAY 27,1997  08:48    PAGE 1
                                                                                                      NSC
                                                                    THIRD                             STATEMENT
                                                                    PARTY  ACCOUNTS RECEIVABLE  WHO'S       REIMB  ON UB
NAME                 BILL NAME             INACTIVE  ABBREVIATION BILL?  CATEGORY             RESPONSIBLE  INS?   BILLS
-------------------------------------------------------------------------------------------------------------------------

CHAMPUS              CHAMPUS                         CHAMPUS      YES    CHAMPUS              INSURER      YES    YES
CHAMPVA REIMB. INS.  REIMBURSABLE INS.               REIM INS     YES    CHAMPVA THIRD PARTY  INSURER      YES    YES
CRIME VICTIM         THIRD PARTY                     CRIME        YES    CRIME OF PER.VIO.    INSURER      NO     YES
DENTAL               DENTAL                          DENTAL       NO     EMERGENCY/HUMANITARI PATIENT      YES    YES
HUMANITARIAN         HUMANITARIAN                    HUMAN        NO     EMERGENCY/HUMANITARI PATIENT      NO     NO
INTERAGENCY          INTERAGENCY                     INTER        YES    INTERAGENCY          OTHER (INST         YES
MEANS TEST/CAT. C    MEANS TEST/CAT. C     NO        MT/CAT C     NO     C (MEANS TEST)       PATIENT      NO     YES
MEDICARE ESRD        MEDICARE ESRD                   MEDICARE     YES    INTERAGENCY          OTHER (INST  NO     YES
MILITARY             MILITARY              NO        MIL          YES    INTERAGENCY          OTHER (INST         YES
NO FAULT INS.        NO FAULT INS.                   NO FAULT     YES    REIMBURS.HEALTH INS. INSURER      NO     YES
REIMBURSABLE INS.    REIMBURSABLE INS.               REIM INS     YES    REIMBURS.HEALTH INS. INSURER      YES    YES
SHARING AGREEMENT    SHARING AGREEMENT               SHARING      YES    SHARING AGREEMENTS   OTHER (INST         YES
```

MCCR System Definition Menu
Charge Master Menu
Fast Enter of New Billing Rates

New Option

The IB SUPERVISOR security key is required to edit.

Introduction

This option is designed to allow quick entry of new rates into the Charge Master for Interagency and Tortiously Liable Billing Rates. This option should only be used for the annual updated Interagency and Tortiously Liable Rates. The charges will be asked for by charge type category: inpatient, outpatient, prescription, outpatient dental, Cat C copayment. Enter all charges for a category, then move to the next section for the next category. For example, you are first prompted for Inpatient Charges. When you have entered all inpatient bedsections and their related charges, a <RET> entered at the "Select Inpatient Bedsection" prompt will bring you to the next charge type, Outpatient, and so on until you have entered the charges for all charge types.

Revenue codes may be edited through the Enter/Edit Charge Master option.

Example

```
Fast Enter of Tortiously Liable and Interagency Rates


     Select one of the following:

          T         Tortiously Liable
          I         Interagency

Enter which rates:  t  Tortiously Liable
Select EFFECTIVE DATE:   10/1  (OCT 01, 1997)

Enter the Revenue Code to use for all non-professional inpatient services:

Room, Board, Nursing Services: 101//   <RET>    ALL INCL R&B      ALL-INCLUSIVE
ROOM AND BOARD
Ancillary Services: 240//   <RET>     ALL INCL ANCIL      GENERAL CLASSIFICATION
```

Example, cont.

```
TORTIOUSLY LIABLE charges effective Oct 01, 1997 will be added as follows:
Charge Type                   Charge Set               Rev Code
------------------------------------------------------------------------------
INPATIENT                   TL-INPT (INCLUSIVE)      001       (All Inclusive)
                            TL-INPT (NPF)            101       (Room,board)
                            TL-INPT (NPF)            240       (Ancillary)
                            TL-INPT (PF)             960       (Physician)
OUTPATIENT VISIT            TL-OPT VST               500
PRESCRIPTION REFILL         TL-RX FILL               257
OUTPATIENT DENTAL           TL-OPT DENTAL            512
CAT C OUTPATIENT COPAYMENT  TL-CAT C OPT COPAY       500

If any of the revenue codes are incorrect then change the Default Revenue for
the Charge set. (except the non-prof inpt rev codes entered above)

If any of the Charge Sets are incorrect DO NOT USE this option.
This option may NOT be used to delete rates or add zero charges.

The charges will be asked in sections based on the Charge Types listed above.
The first section is INPATIENT, enter all Inpatient Bedsections and their
charges, then press return at the Select Bedsection prompt to move to the
OUTPATIENT VISIT section and enter the Outpatient Visit Bedsection and
charge...

Enter RETURN to continue or '^' to exit:   <RET>

------------------------------------------------------------------------------
Enter INPATIENT TORTIOUSLY LIABLE charges effective Oct 01, 1997:
------------------------------------------------------------------------------

          Select INPT BEDSECTION:   <RET>

------------------------------------------------------------------------------
Enter OUTPATIENT VISIT TORTIOUSLY LIABLE charges effective Oct 01, 1997:
------------------------------------------------------------------------------

          Select OPT VISIT BEDSECTION: OUTPATIENT VISIT//    <RET>          12
OUTPATIENT VISIT                                  500  $ =    <RET>

          Select OPT VISIT BEDSECTION:   <RET>

------------------------------------------------------------------------------
Enter PRESCRIPTION REFILL TORTIOUSLY LIABLE charges effective Oct 01, 1997:
------------------------------------------------------------------------------

          Select RX REFILL BEDSECTION: PRESCRIPTION//    <RET>          9
PRESCRIPTION                                      257  $ =    <RET>

          Select RX REFILL BEDSECTION:   <RET>
```

MCCR System Definition Menu
Charge Master Menu
Fast Enter of New Billing Rates

Example, cont.

```
-------------------------------------------------------------------------------
Enter OUTPATIENT DENTAL TORTIOUSLY LIABLE charges effective Oct 01, 1997:
-------------------------------------------------------------------------------

          Select OPT DENTAL BEDSECTION: OUTPATIENT DENTAL//     <RET>
OUTPATIENT DENTAL                                 512  $ = 100.00//     <RET>

          Select OPT DENTAL BEDSECTION:    <RET>

-------------------------------------------------------------------------------
Enter CAT C OUTPATIENT COPAYMENT TORTIOUSLY LIABLE charges effective Oct 01,
1997:
-------------------------------------------------------------------------------

          Select CAT C OPT COPAY BEDSECTION: OUTPATIENT VISIT//     <RET>       12
OUTPATIENT VISIT                                  500  $ =     200            added

          Select CAT C OPT COPAY BEDSECTION:    <RET>
```

MCCR System Definition Menu
Charge Master Menu
Delete Charges from the Charge Master

New Option

The IB SUPERVISOR security key is required to edit.

Introduction

This option is used to delete charges from a Charge Set that are no longer needed. All charges that are inactive or that have been replaced before the specified date are deleted. A report of charges that *will be* deleted based on the date entered can be printed before the actual deletion to confirm the charges should be deleted.

Example 1 - Print List of Charges

```
**** DELETE INACTIVE CHARGE ITEMS FROM A CHARGE SET ****

For a given Charge Set, this option allows deletion of all chargeable items
that have been inactivated or replaced before a certain date.

     Since all charges for a billing rate and date range may be deleted with
     this option, caution is advised.


The Charge Set to delete Charge items from:
Select CHARGE SET NAME:  TL-OPT DENTAL

Delete ALL charges for this Charge Set?   YES

     Select one of the following:

          1         Print List of Charges that will be Deleted
          2         Delete Charges

Enter response:  1  Print List of Charges that will be Deleted
OUTPUT DEVICE: HOME//  <RET>  LAT    RIGHT MARGIN: 80//   <RET>
```

MCCR System Definition Menu
Charge Master Menu
Delete Charges from the Charge Master

Example 1 - Print List of Charges, cont.

```
Charges (to be deleted) in TL-OPT DENTAL set (ALL CHARGES IN SET)May 28, 1997
09:49  Page 1
Charge Item                        Effective   Inactive        Charge   Rev Cd
-------------------------------------------------------------------------------

                    CHARGE SET: TL-OPT DENTAL

OUTPATIENT DENTAL                  10/01/92                     97.00
OUTPATIENT DENTAL                  10/01/93                    102.00
OUTPATIENT DENTAL                  10/01/94                    119.00
OUTPATIENT DENTAL                  10/01/95                    104.00
OUTPATIENT DENTAL                  10/01/96                    121.00

5 Charges to be deleted
Enter RETURN to continue or '^' to exit:
```

Example 2 - Delete Charges

```
**** DELETE INACTIVE CHARGE ITEMS FROM A CHARGE SET ****

For a given Charge Set, this option allows deletion of all chargeable items
that have been inactivated or replaced before a certain date.

     Since all charges for a billing rate and date range may be deleted with
     this option, caution is advised.


The Charge Set to delete Charge items from:
Select CHARGE SET NAME:    TL-OPT DENTAL

Delete ALL charges for this Charge Set?    NO

All charges inactive before this date will be deleted:
Select INACTIVE DATE:    10/1/95  (OCT 01, 1995)

     Select one of the following:

          1         Print List of Charges that will be Deleted
          2         Delete Charges

Enter response:  2  Delete Charges


All charges inactive before 10/01/95 for TL-OPT DENTAL will be deleted.

Is this correct, do you want to continue?    YES
Beginning Deletions
3 charges deleted.
```

MCCR System Definition Menu
Charge Master Menu
Inactivate/List Inactive Codes in Charge Master

New Option

Introduction

This option searches the charges in the Charge Master for inactive CPT codes. It then inactivates all charges associated with those inactive CPT codes. To confirm the charges should be inactivated, a report of charges for inactive CPT codes may be printed.

Example

Print List

```
**** INACTIVATE CHARGE ITEMS FOR ALL CURRENTLY INACTIVE CPTS ****

     For all Charge Sets based on CPT procedures, this option will add an
     Inactive Date to each Charge Item that is a currently Inactive CPT code.


The date that should be added as the Inactive Date for the Charges
associated with Inactive CPTs:

Select INACTIVE DATE:    t  (MAY 29, 1997)

     Select one of the following:

          1         Print List of Active Charges for Inactive CPT's
          2         Inactivate Charges for Inactive CPT's

Enter response:  1  Print List of Active Charges for Inactive CPT's
OUTPUT DEVICE: HOME//  <RET>  LAT    RIGHT MARGIN: 80//   <RET>
..


Charges for Inactive CPT's                        May 29, 1997  13:47  Page 1
Charge Item        Effective   Inactive    Charge Set            Charge   Rev
Cd
------------------------------------------------------------------------------
00806              02/01/95               AMB SURG REGION       394.00    333
11701              02/01/95               AMB SURG REGION       343.34
11701 - 54         05/01/96               AMB SURG REGION        34.20
25146 - 66         02/01/95               AMB SURG REGION       942.00
25153              05/01/96               AMB SURG REGION       234.23

5 Charges for Inactive CPT's
```

MCCR System Definition Menu
Charge Master Menu
Inactivate/List Inactive Codes in Charge Master

Example, cont.

Inactivate Charges

```
**** INACTIVATE CHARGE ITEMS FOR ALL CURRENTLY INACTIVE CPTS ****

     For all Charge Sets based on CPT procedures, this option will add an
     Inactive Date to each Charge Item that is a currently Inactive CPT code.


The date that should be added as the Inactive Date for the Charges
associated with Inactive CPTs:

Select INACTIVE DATE:    t  (MAY 29, 1997)

     Select one of the following:

          1         Print List of Active Charges for Inactive CPT's
          2         Inactivate Charges for Inactive CPT's

Enter response:  2  Inactivate Charges for Inactive CPT's


All charges for currently Inactive CPT codes will become inactive after
05/29/97

Is this correct, do you want to continue?    y  YES
Beginning Inactivations
..5 charges inactivated
```

SECTION 5 - SYSTEM MANAGER'S INTEGRATED BILLING MENU

Select Default Device for Forms
Forms Output Utility
Charge Master IRM Menu
Display Integrated Billing Status
Enter/Edit IB Site Parameters
Inquire an IB Action
Patient IB Action Inquiry
Purge Menu
Repost IB Action to Filer
Start the CHAMPUS Rx Billing Engine
Start the Integrated Billing Background Filer
Stop the CHAMPUS Rx Billing Engine
Stop the Integrated Billing Background Filer
Verify RX Co-Pay Links

Option Overview

SELECT DEFAULT DEVICE FOR FORMS - Used to select the default devices on which UB-82, UB-92, and HCFA-1500 forms will print.

FORMS OUTPUT UTILITY - This option displays a list of local forms defined for your site and the associated actions allow you to add local forms and data elements and to override specific fields on a local form associated with the national one. It also allows you to define a local SCREEN 9 for bill data entry.

CHARGE MASTER IRM MENU

LOAD HOST FILE INTO CHARGE MASTER - This option allows new rates and charges to be added to the Charge Master form host files. This is only available for specific rates and charges.

RATE SCHEDULE - This option allows the enter/edit of the Rate Schedule Adjustment field (#363.10). This field causes all charges for a particular schedule to be adjusted by a site defined amount.

DISPLAY INTEGRATED BILLING STATUS - Allows you to view data from the IB SITE PARAMETER file and pertinent information about the status of the IB background filer.

ENTER/EDIT IB SITE PARAMETERS - Allows you to enter or edit the INTEGRATED BILLING SITE PARAMETER file.

INQUIRE AN IB ACTION - Provides a display of a captioned inquiry for a specified IB action.

PATIENT IB ACTION INQUIRY - Provides a brief display of IB actions for a selected patient and date range.

PURGE MENU

PURGE UPDATE FILE - Used to delete all CPT entries in the temporary file, UPDATE BILLABLE AMBULATORY SURGICAL CODE (#350.41) that have been successfully transferred to the permanent file, BILLABLE AMBULATORY SURGICAL CODE (#350.4).

ARCHIVE BILLING DATA - Used to archive data contained in search templates.

ARCHIVE/PURGE LOG INQUIRY - Used to provide a full inquiry of any entry in the IB ARCHIVE/PURGE LOG file (#350.6).

DELETE ENTRY FROM SEARCH TEMPLATE - Used to remove entries that you do not wish to purge from the search template.

FIND BILLING DATA TO ARCHIVE - Used to identify records that meet the criteria to be archived and purged from the INTEGRATED BILLING ACTION file (#350), the CATEGORY C BILLING CLOCK file (#351), and the BILL/CLAIMS file (#399).

LIST ARCHIVE/PURGE LOG ENTRIES - Used to list all log entries in the IB ARCHIVE/PURGE LOG file (#350.6).

LIST SEARCH TEMPLATE ENTRIES - Used to list all entries in a search template that are scheduled to be archived and subsequently purged.

PURGE BILLING DATA - Used to purge data from the INTEGRATED BILLING ACTION file (#350) (pharmacy copayment transactions only), the CATEGORY C BILLING CLOCK file (#351), and/or the BILL/CLAIMS file (#399).

REPOST IB ACTION TO FILER - Allows Integrated Billing action entries that did not successfully pass to Accounts Receivable to be reposted to the IB filer.

START THE CHAMPUS RX BILLING ENGINE - This option is used by IRM personnel to queue the background filer to run.

START THE INTEGRATED BILLING BACKGROUND FILER - Used to force a filer to start running when a filer job has terminated unexpectedly.

STOP THE CHAMPUS RX BILLING ENGINE - This option may be used to gracefully shut down the billing engine if a planned system shutdown is scheduled to occur, or if the RNA system is scheduled to be shutdown.

STOP THE INTEGRATED BILLING BACKGROUND FILER - Used to shutdown the IB background filer.

VERIFY RX CO-PAY LINKS - Compares the softlink stored in Integrated Billing with the pointer in the PRESCRIPTION file pointing back to Integrated Billing, to provide a display/print-out of all integrated billing actions which do not verify for a selected range of reference numbers.

Select Default Device for Forms

Two new fields:
PRINT FORM NAME - used by the Forms Output Utility. If this name is not entered, the UB-92 and HCFA-1500 forms will not use the Forms Output Utility to print bills.
LOCAL SCREEN 9 - used by the Enter/Edit Billing Information option as the name of the special form to display a local screen.

Introduction

This option is used to select the default devices on which third party claim forms will print. The devices entered through this option will appear as the default devices when using options which generate these forms. Separate devices may be entered for each type of form.

You will be prompted for the form type. To avoid making duplicate entries of the same form type, it is suggested you type <??> at this prompt to first view the selections.

You will then be prompted for a default printer (in Billing) and a follow-up printer (in Accounts Receivable). You **must** enter an Accounts Receivable default device for follow-ups for every form except the UB-82.

In order to utilize the Print Authorized Bills option on the Third Party Billing Menu, you must set up billing default printers for each form type through this option. Any form type not set up with a billing default printer will not print when utilizing the Print Authorized Bills option.

The billing default printer must be added for the BILL ADDENDUM form type in order for the addendums to automatically print for every HCFA-1500 bill with prescription refills or prosthetic items.

Select Default Device for Forms

Example

```
Select BILL FORM TYPE NAME:   <??>
ANSWER WITH BILL FORM TYPE NUMBER, OR NAME
CHOOSE FROM:
   1           UB-82
   2           HCFA-1500
   3           UB-92
   4           BILL ADDENDUM

Select BILL FORM TYPE NAME:   1  UB-92
NAME: UB-92//  <RET>
DEFAULT PRINTER (BILLING):   B50
FOLLOW-UP PRINTER (A/R):   <RET>
PRINT FORM NAME:  UB-92
LOCAL SCREEN 9:

Select BILL FORM TYPE NAME:   2  HCFA-1500
NAME: HCFA-1500//  <RET>
DEFAULT PRINTER (BILLING):   A200
FOLLOW-UP PRINTER (A/R):   750C
PRINT FORM NAME:  HCFA-1500
LOCAL SCREEN 9:

Select BILL FORM TYPE NAME:   3  UB-92
NAME: UB-92//  <RET>
DEFAULT PRINTER (BILLING):   A100
FOLLOW-UP PRINTER (A/R):   700D
PRINT FORM NAME:  UB-92
LOCAL SCREEN 9:

Select BILL FORM TYPE NAME:   4  BILL ADDENDUM
NAME: UB-92//  <RET>
DEFAULT PRINTER (BILLING):   A200
FOLLOW-UP PRINTER (A/R):   750C
PRINT FORM NAME:  BILL ADDENDUM
LOCAL SCREEN 9:
```

Forms Output Utility

New Option

Introduction

This option displays a list of local forms defined for your site and the associated actions allow you to add local forms and data elements and to override specific fields on a local form associated with the national one. It also allows you to define a local SCREEN 9 for bill data entry.

List of Local Forms Screen

Actions

Add Local Form
This action allows you to define local output billing forms and local input data screens that are not supported nationally but are needed for specific insurance companies or bill types. It provides the ability to create new forms/screens from scratch, as well as provides for two ways to easily create a new form "copy" based on an existing nationally released form.

The WANT TO ASSOCIATE THIS FORM WITH A NATIONAL FORM? field allows you to associate a new local form with a nationally released form without actually copying any data. This association allows each site to create a local form, but only require modifications to the fields of the form that are different from the nationally released definitions. Any form field definition that is not changed on the local form will continue to use the standard national definition. Any changes from the national definition however, will be stored as local entries that, when a bill is generated using this local form definition, will override the nationally released definition for these changed fields only. This way, data changes can be made without the site having to take responsibility for maintaining the entire form. Only forms that have the same BASE FILE NUMBER and FORM TYPE can be copied. Any local changes made must be tracked carefully as the site will be responsible for maintaining any locally modified fields should future changes become necessary. Since unmodified fields still rely on the national form for their definition, any changes made via a nationally released update to unmodified fields on the form will be automatically incorporated into a local form definition associated with a national form definition.

Forms Output Utility

Introduction, cont.

The WANT TO COPY ALL FIELDS FROM AN EXISTING FORM? field allows a straight copy, where the field definitions for a selected form are all copied into new entries referencing the new local form. Any local form created via an "unassociated" copy will have NO link back to the national form once the copy is completed.
Since no changes to nationally released software will be made to these local entries, you are free to modify the new form definition in whatever way you need to and are responsible for any and all changes that are made or will need to be made in the future.

Form View/Edit
Allows you to view and edit a selected form. This action brings you to the Detailed View of Local Form Screen. See below.

Add/Edit Local Data Elements
Allows you to define local data elements that are not supported nationally but are needed to be included on one or more local billing form(s). Nationally released data element definitions CANNOT be modified via this action.

View Data Element
Allows you to view the description, extract code, and other attributes of any data element defined at the site, both national and local.

Test Form
Allows you to test the output of a selected form.

Detailed View of Local Form Screen

Edit Local Form Demographics
Allows you to edit the name, description, pre and post processing logic and the extract and output logic for local forms.

Delete A Local Form
Allows you to delete a locally defined form. When the form is deleted, all form fields and form field definitions (not data element definitions) associated with that form are also deleted.

Edit Form Fields
Allows you to edit the field content defined for a local form associated with a national form that has local "override" field content definitions; or to edit any local, unassociated form field's form position data and field content definitions. This action brings you to the Bill Form Fields Screen. See below.

Switch Form
Allows you to switch between forms without exiting the option.

Bill Form Fields Screen

Add Local/Override Field
Allows you to add fields to a local unassociated form and allows the addition of 'override' fields for local modifications to any form.

Delete Local Form Field
Allows you to delete the 'override' form field content definitions for a local form associated with a national form or to delete any fields defined for an unassociated local form that do not have override fields defined for them (You must delete any override fields first).

Edit Local Form Field
Allows you to edit the field content for a local form such as page or sequence, first line number, starting column or piece, maximum number of lines, short description, etc.

Local Field Content Definition
Allows you to edit the "override" form field content definitions for a local form associated with a national form, or to edit the form field content of any field on an unassociated local form.

Add/Edit Local Data Elements
Allows you to define local data elements that are not supported nationally but are needed to be included on one or more local billing form(s). Nationally released data element definitions CANNOT be modified via this action.

View Data Element
Allows you to view the description, extract code, and other attributes of any data element defined at the site, both national and local.

View Form Fields
Allows you to view the composition of a local 'override' or national form field for a local form. This includes both the form field's form position data as well as the associated form field content definition.

Introduction, cont.

Example 1 - CUSTOM BILL PRINT
Your site needs to print the total charge, not unit charge, in Block 24F on the HCFA 1500.

1. If there is not currently a local form defined for the HCFA 1500, use the ADD A LOCAL FORM option to add a form that will become the local HCFA 1500. Base file will be 399, print form type will be P (printed). Respond Yes to associate with national form question and choose the HCFA 1500 as the parent form. Give it a form length of 66 and enter a short description like Local 1500. Since this form is now "associated" with the national HCFA 1500 form, all of the fields will default to the definition provided by the national HCFA 1500 form when the bills are printed. The only time you'll want to change the pre and post processing, edit or output routines is if you do not want the national defaults, but want to write your own. Be very careful if you change any of these executable fields.

2. Select View Form and, if prompted for selection, enter the local HCFA 1500 form sequence # from the list displayed. This will display the general characteristics of this form.

3. Choose the Edit Form Fields action (FF). This will display a list of the form fields that make up this form.

4. Press return for NEXT SCREEN until the field CHARGES (BX-24F) appears in the field list.

5. The charge field is a data element that is not able to be extracted on its own. Its value depends on the "line" within box 24 that it will print on because it depends on revenue, code, date, etc. This kind of data element is considered part of a "group" element and that group element must be extracted before any of its group member data element can be output. The group data element for charges is N-HCFA 1500 SERVICES (PRINT). If you use the View Data Element option and enter this group element name, you'll see it sets up the array, IBXSAVE("BOX24",line #) for later use by its group member elements. You will also see that the 9th "^" piece of this array is the # of units. This is a calculate only field (no output from it when it is processed).

6. Select the Add Local/Override Field option and enter the sequence number of the CHARGES field.

Example 1, cont.

7. Respond Yes to OK? prompt and to the copy over from the original field question. This is almost always a good idea so you can see what the original format of the field was.

8. Leave the data element field the same and do not enter an insurance company or bill type unless you want to restrict this change to a specific insurance company and/or bill type.

9. Now change the format field to multiply the value of charges (in variable IBXDATA(line #)) by the value of the units on the corresponding line # (in the 9th "^" piece of IBXSAVE("BOX24",line #)).

   Replace $J(IBXDATA(Z)
   With $J(IBXDATA(Z)*$P($G(IBXSAVE("BOX24",Z)),"^",9)

10. Now modify the format description to reflect the change you just made, and the override of the field is complete.

11. To make the formatter print the local copy of the HCFA 1500, use the IRM menu option, Select Default Device For Forms, and enter the name of your local form as the value of the PRINT FORM field. The next time a HCFA 1500 bill prints, it will print the charges as total charges, not a unit charge.

Example 2 - LOCAL SCREEN 9

Your site needs to print the provider's phone number in Form Locator 11 on the UB-92 for inpatient bills for insurance company Blue Cross of East Wherever and this data is not currently captured in VISTA.

There are several steps involved in this task. First, you must set up a local field for this data in the bill/claims file and define a local data element in the forms data element file, then create or modify a local Screen 9 to enable the clerks to input this data for this insurance company's bills. You then need to edit your local UB-92 print form to include this data in Form Locator 11 for this insurance company and attach this local Screen 9 to the national UB-92 bill form. Only the steps for the creation of local Screen 9 are included here.

Example 2, cont.

1. Use Fileman to add a local form field, numbered at least 10000 and stored on a numeric node of at least 10000 for this new data element. These are the only kind of fields that can be INPUT on a local Screen 9 (any field can be displayed).

2. Using the output formatter, select the Add/Edit Local Data Elements action. Enter a name for this new data element. Only national fields can start with N-, so any other name is valid. Set the base file to 399 and the type of element to "F" (Fileman). Type the name that you gave the local field in step 1 as the Fileman field reference. Make sure you type it correctly as no edit checks are made on the field at this point. For Fileman return format, use "I" if you want the "raw" data returned or "E" if you want Fileman to return it in display format. Then enter a description of the field so you can identify it the next time you need to see the list of local data elements.

3. Again using the output formatter, if there is not currently a local form defined for local Screen 9 for the national UB-92 form, use the ADD A LOCAL FORM option to add this form. Base file will be 399, print form type will be S (screen). Respond No to associate with national form question and to the copy fields form another form question. Enter a short description. For now, do not put any code in the form pre and post processing fields. Code can be written to do edits for the data on the screen that will prevent it from being authorized unless the edits are passed (post-processing). The pre-processing is used to set up any variables that may be needed to process this screen. The pre-processing is executed before the screen is displayed, the post-processing takes place after the standard authorize edits are executed upon leaving the bill.

4. Select View Form (VF) and, if prompted for selection, enter the local UB-92 screen form sequence #. This will display the general characteristics of this form.

5. Choose the Edit Form Fields action (FF). This will display a list of the form fields that make up this form or, if a new form, will display "No fields currently defined for this form".

6. Choose Add Local/Override Field action (AF). If there are any fields already defined for this screen, there will be a prompt to allow you to override an existing field. Respond No if this question is asked. Respond 1 for page/seq then enter the number of the line on the screen where you want to prompt for

Example 2, cont.

this field to appear and the column the prompt should start in. Skip max # of lines since this data element can have only one value per bill. Enter a length for the field and it should be long enough to hold the data and its prompt, if one is desired. Leave pad as none, and edit status as editable. Give it an edit group number that is different from any other group that may already be on the screen. For this data element, assume the field will be output exactly as it is stored, so no format code is needed.

7. Now follow steps 1-3 in the first example, but use the UB-92 national form wherever it says to use the HCFA 1500.

8. Press return for NEXT SCREEN until the field FORM LOCATOR 11 (FL-11/1) appears in the field display area.

9. Select the Add Local/Override Field action and enter the sequence number of the FORM LOCATOR 11 (FL-11/1) field.

10. Respond Yes to OK? prompt and No to the copy over from the original field question. This is OK in this case because the new data element is a single-valued field that has absolutely nothing to do with the field it is overriding.

11. Enter the name of your local data element for the provider phone number in the data element field. Enter the BLUE CROSS of EAST WHEREVER insurance company name at the insurance company prompt. Enter bill type as inpatient to restrict this change to a specific bill type for this one insurance company. There is no need to enter Format code or description as we're assuming the data is displayed the same way it is stored in the database. If you want it displayed with dashes, but store just the numerics, you can reformat it using M code here. Make sure there is a FileMan input transform on the data field to strip out the dashes before it stores it. This will now be the override field output for inpatient bills for the BL CR of EAST WHEREVER insurance company's form locator 11.

12. To make the formatter print the local copy of the UB-92 and to associate this local Screen 9 with the UB-92 form type, use the IRM menu option, Select Default Device For Forms, and enter the name of your local form as the value of the PRINT FORM field and the name of your local UB-92 Screen 9 as the local form you just created/edited.

Example 2, cont.

13. The next time a UB-92 bill is entered/edited whose insurance company is BL CROSS of EAST WHEREVER, there will be a Screen 9 available to allow entry of the provider phone #. This field will also print on the UB-92 as the first line in Form Locator 11 when the bill is printed.

Charge Master IRM Menu
Load Host File Into Charge Master

New Option

Introduction

This option allows new rates and charges to be added to the Charge Master form host files. This is only available for specific rates and charges. The Host file must be in a predefined format to be read correctly. Following are the available choices.

Load CMAC into XTMP - Upload the CMAC from a host file.

Load AWP into XTMP - Upload Average Wholesale Price list from a host file.

Assign Charge Set - Assign charges loaded into XTMP to Charge Sets.

Check Data Validity - Check files waiting to be loaded into the Charge Master for data validity.

Load into Charge Master - Check files waiting to be loaded into the Charge Master for data validity, and upload them.

Delete XTMP files - Delete files in XTMP.

Example

```
Select one of the following:

          1.1       Load CMAC into XTMP
          1.2       Load AWP into XTMP
          2         Assign Charge Set
          3         Check Data Validity
          4         Load into Charge Master
          5         Delete XTMP files

Enter response: 1.1  Load CMAC into XTMP

Upload the CMAC from a host file:   'CMACxxx.TXT'   w/xxx = locality

CMAC Host files available for upload in: DISK$VA3:[HARPER]

                                CMAC184.TXT
                                CMAC185.TXT
```

Charge Master IRM Menu
Load Host File Into Charge Master

Example, cont.

```
Enter a Host File Name:  CMAC184.TXT


Professional Component Modifier: //   <RET>

       Professional Component charges will not be uploaded.

Technical Component Modifier: //   <RET>

       Technical Component charges will not be uploaded.


Proceed with upload now?  YES

Loading CMAC184.TXT into ^XTMP
.................................................
...................

Done. 6836 lines processed.
The following files were created, they will be purged in 2 days:

A)  IB upload of Host file CMAC184.TXT, on 5/30/97@10:53:45 by HARPER,A

    IBCR UPLOAD CMAC184.TXT  184        Count = 12849     Item = CPT

             Subfile                Count       Charge Set
             -------                -----       -------------------------
        1    CLASS 1                6836
        2    CLASS 2                21
        3    CLASS 3&4              5992
```

Charge Master IRM Menu
Rate Schedule Adjustment Enter/Edit

New Option

Introduction

This option allows the enter/edit of the Rate Schedule Adjustment field (#363.10). This field causes all charges for a particular schedule to be adjusted by a site defined amount. It requires M-code that is executed to provide the adjusted amounts and; therefore, requires programmer access (DUZ(0)="@").

This Adjustment will have an immediate effect on the charges of the Rate Schedule. The Adjustment must be correct before the option can be exited.

Example

```
Select RATE SCHEDULE NAME:   IA-OPT

       The base unit charges are not currently Adjusted.

ADJUSTMENT:  S X=X+3

       If the base unit charge is $100,
       this Adjustment will result in a charge of: $      100.00

Is this correct?  YES
```

System Manager's Integrated Billing Menu
Start the CHAMPUS Rx Billing Engine

New Option

Introduction

This option is used by IRM personnel to queue the background filer to run. Several parameters must be set before this job can be queued to run; if they are not set, the job will not be queued. This job actually will cause four jobs to be queued. The first job is the background filer itself. After this job has been queued and has successfully opened a TCP/IP channel with the RNA system, this job will queue off a secondary filer job. If the first job aborts in any way, the secondary filer will assume the responsibilities of the primary filer and spawn another secondary filer. The option also directly queues a second job to open a separate TCP/IP channel with the RNA system to receive updates of the Average Wholesale Pricelist (AWP). This update is normally received weekly. The AWP Update job will also spawn a secondary job, in a manner similar to the background filer, which will take over for the primary AWP update job if that job aborts. Note that after the AWP Update is received, members of the IB CHAMP RX START mail group will receive an alert notifying the user that the update has completed.

Example

```
Is it okay to queue these jobs to run?    YES

The CHAMPUS billing engine has been queued as task# 381990.

The AWP Update engine has been queued as task# 381991.
```

System Manager's Integrated Billing Menu
Stop the CHAMPUS Rx Billing Engine

New Option

Introduction

This option may be used to gracefully shut down the billing engine if a planned system shutdown is scheduled to occur, or if the RNA system is scheduled to be shutdown. The option sets a flag which calls for both the background filer and AWP update engine to stop running. The secondary jobs for both of these jobs will shutdown as well.

Example

```
Are you sure you wish to shut down these jobs?    y  YES

The CHAMPUS Billing and AWP Update engines will be shut down.
```

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